

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05454

CERTIFICATE OF DEATH

05447

1. PLACE OF DEATH a. COUNTY Harford MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland b. COUNTY Harford			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cardiff			c. LENGTH OF STAY IN 1b 64 years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cardiff		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Main Street				d. STREET ADDRESS Main Street		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) EFFIE M. ARTHUR				4. DATE OF DEATH Month April Day 3 Year 1969			
5. SEX Female		6. COLOR OR RACE White		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Jan. 25, 1874	
9. AGE (In years last birthday) yrs. 95		10. USUAL OCCUPATION (Give kind of work done during most of working life and if retired) Housewife		11. BIRTHPLACE (County & State, or foreign country) Aberdeen, Md.		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME Luther S. Osborn				14. MOTHER'S MAIDEN NAME Sarah R. Wells			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)		16. SOCIAL SECURITY NO. 218-46-3249		17. INFORMANT Address Mrs. Helen A. Heaps, Cardiff, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4123 Myocardial clausuff. crumg IMMEDIATE CAUSE (a) Ant. occlusive CV Disease DUE TO (b) lost. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)					
20c. TIME OF INJURY Month, Day, Year Hour ' a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from 1942 to April 3, 1969 , that (I) (we) last saw the deceased alive on April 3, 1969 , and that death occurred at 1 PM , from causes and on the date stated above.							
22a. SIGNATURE Josiah A. Hunt				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED April 4, 1969	
22c. PHYSICIAN'S NAME (Type) Josiah A. Hunt				22d. ADDRESS Delta, Penna.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Apr. 7, 1969		23c. NAME OF CEMETERY OR CREMATORY Slate Ridge		23d. LOCATION (City or Town) (County) (State) Delta York Penna.	
24. FUNERAL DIRECTOR JOHN H. HARKINS				25a. REC'D BY REGISTRAR DATE APR 8 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	

MEDICAL CERTIFICATION

00-554

CERTIFICATE OF DEATH

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VR A15
45M - 1969

05455		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				05448	
1. DECEASED NAME (Type or print)		First	Middle	Lost	20. DATE OF DEATH		2b. HOUR
DAVID Fred Ayers					April Month 25 Day 1969 Year		5:40 PM
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)	7. UNDER 1 YEAR
Male		White		Dec. 12, 1894		74 YRS.	MONTHS DAYS HOURS MIN
70. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
VA.		U.S.A.				Harford Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		120. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Havre de Grace		Harford Memorial Hosp.		Pipefitter		US-Govt. Ret.	
130. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Md		Harford		Baltimore		13e. STREET AND NUMBER	
14. FATHER'S NAME		First	Middle	Lost	15. MOTHER'S MAIDEN NAME		
Martin		--	Ayers		Unknown		
160. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT			
no		218-07-0460		Mrs. Leona H. Ayers, Wright's Trailer Village			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a)		Chronic Cardiac Decompensation					
4124		1 month					
DUE TO, OR AS A CONSEQUENCE OF		A.S. C.V.D. Class IV, E					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		(b) DUE TO, OR AS A CONSEQUENCE OF					
		(c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		Pleural effusion					
190. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		200. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
210. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
Hour A.M. Month Day Year		P.M. 19					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		City or Town County State	
				Street or R.F.D. No.			
220. I certify that (I) (this hospital) attended the deceased from 4-14, 1969, to 4-25, 1969, that (I) (we) last saw the deceased alive on 4-25, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		22c. DATE SIGNED		22e. ADDRESS			
Edward C. Loo, M.D.		4/25/69		Havre de Grace, Md.			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		22f. ADDRESS			
Edward C. Loo, M.D.		Havre de Grace, Md.					
230. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
Burial		April 28, 1969		Jarrettsville Cemetery		Jarrettsville Harford Md	
24. FUNERAL DIRECTOR		24b. ADDRESS		250. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Howard K. McComas & Son, Abingdon, Md.				DATE APR 28 1969		Charles J. J...	

85455

RECEIVED BY THE DIRECTOR

April 22 1953

Mr. J. Edgar Hoover

Washington, D. C.

Dear Sir:

I am writing to you regarding the matter of the

investigation of the activities of the

Communist Party, U. S. A.

and the activities of the

Communist Party, U. S. A.

and the activities of the

Communist Party, U. S. A.

and the activities of the

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
05456		05449									
1. DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH		2b. HOUR	
Rosa Lee Ayres								April 1 Month 8 Day 1969 Year		12 ⁴⁵ HRS.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Female		White		Jan. 6, 1918		51 YRS.		MONTHS		DAYS	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Maryland		U.S.A.				Harford					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
Abingdon		3205 Emmorton Road		Seamstress		Garment					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER			
Maryland		Harford		Abingdon				3205 Emmorton Road			
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First Middle Last	
John J. Ayres Jr.								Elmina -- Gross			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
no				215-16-9114		Elmina G. Ayres, 3205 Emmorton Road, Abing-		don, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) 1538 Cancer of large bowel										3 yrs.	
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.											
DUE TO, OR AS A CONSEQUENCE OF											
(b)											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 1967, to April 1, 1969, that (I) (we) last saw the deceased alive on April 2, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE		ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED			
William A. Tyson								4-8-69			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS									
William A. Tyson		Kingsville Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		April 11, 1969		Cokesbury Memorial Cemetery		Abingdon Harford Md					
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Howard K. McComas & Son, Abingdon, Md.		APR 11 1969		J. Charles Judge							

MEDICAL CERTIFICATION

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or Print) Valerie ANN Baker			2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input checked="" type="checkbox"/> Day <input checked="" type="checkbox"/> Year April 1 1969			2b. HOUR M				
3. SEX F	4. RACE W	5. DATE OF BIRTH Dec. 1, 1949	6. AGE (In years last birthday) 19 YRS.	IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>	IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN <input type="checkbox"/>	2c. DATE PRONOUNCED DEAD Month April Day 1 Year 1969		2d. HOUR 6:40 PM		
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Harford				
10. CITY OR TOWN OF DEATH Havre de Grace			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Dorchester Memorial Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Housewife		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 8700 Lochbend	
14. FATHER'S NAME First Charles Middle F. Last Becker			15. MOTHER'S MAIDEN NAME First Dorothy Middle M. Last Banks							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16b. SOCIAL SECURITY NO.		17. INFORMANT Mr. Roger G. Baker		ADDRESS (Same)			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia due to drowning DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year April 1 1969		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Sail boat Capsized					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Crowning Lake		21f. LOCATION Street or R.F.D. No. Darlington		City or Town Hd		County Md.		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE Gerald C Palmer			M.D. Gerald C. Palmer, M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED 4-2-69		
EXAMINER'S NAME (Type)						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county)		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/5/69.		23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Mem. Cemetery			23d. LOCATION (City or Town) Baltimore, Md.		(County) (State)	
24. FUNERAL DIRECTOR Leonard J. Ruck, Inc. Balto. Md. 21214						25a. REC'D BY REGISTRAR APR 3 1969		25b. REGISTRAR'S SIGNATURE Charles J. J...		

12547

STATE
OF NEW YORK

IN SENATE
January 1, 1908

REPORT
OF THE

COMMISSIONERS OF THE LAND OFFICE

FOR THE YEAR 1907

ALBANY:

THE STATE PRINTING OFFICE

1908

Price, 50 Cents

Per copy, 10 Cents

By mail, 15 Cents

Postage paid

NEW YORK

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VR A15ME (5)
10M REV. 1/68

4230

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MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
05459 CERTIFICATE OF DEATH 05452									
1. DECEASED-NAME (Type or print) John B Bauguess			2a. DATE OF DEATH Month April Day 17 Year 1969			2b. HOUR 1A. M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH August 15, 1875		6. AGE (In years last birthday) 93 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) North Carolina		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Harford County, Md.			
10. CITY OR TOWN OF DEATH Bel Air		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 321 George Street		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Farmer		12b. KIND OF BUSINESS OR INDUSTRY Agriculture			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN Bel Air		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 321 George Street	
14. FATHER'S NAME First William Middle Bauguess Last Bauguess			15. MOTHER'S MAIDEN NAME First Bird Middle Bird Last Bird						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown) No (If yes give war or dates of service) ----		16b. SOCIAL SECURITY NO. 223-50-1671		17. INFORMANT (Daughter) 838-8328 321 George Street Mrs. Dorothy Jane Young Bel Air, Md. 21014					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro-vascular Accident 4124 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio-sclerotic C.V. Disease DUE TO, OR AS A CONSEQUENCE OF (c) Arterio-sclerotic C.V. Disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 17									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) Acute Gastr-enteritis									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from April 11, 1969 , to April 15, 1969 , that (I) (we) last saw the deceased alive on April 14, 1969 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE J. Ralph Horky					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED April 17, 1969		
22d. PHYSICIAN'S NAME (Type) J. Ralph Horky, M.D.					22e. ADDRESS Churchville, Maryland 21028				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE April 19, 1969		23c. NAME OF CEMETERY OR CREMATORY Corinth Baptist Church Cem., Rugby, Grayson Co., Va.		23d. LOCATION (City or Town) (County) (State)			
24. FUNERAL DIRECTOR Joseph William Foster W. Broadway & Williams Bel Air, Maryland 21014				25a. REC'D BY REGISTRAR APR 18 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			

1. 1001, 11, 1909
 2. 1002, 11, 1909
 3. 1003, 11, 1909
 4. 1004, 11, 1909
 5. 1005, 11, 1909
 6. 1006, 11, 1909
 7. 1007, 11, 1909
 8. 1008, 11, 1909
 9. 1009, 11, 1909
 10. 1010, 11, 1909

11. 1011, 11, 1909
 12. 1012, 11, 1909
 13. 1013, 11, 1909
 14. 1014, 11, 1909
 15. 1015, 11, 1909
 16. 1016, 11, 1909
 17. 1017, 11, 1909
 18. 1018, 11, 1909
 19. 1019, 11, 1909
 20. 1020, 11, 1909

21. 1021, 11, 1909
 22. 1022, 11, 1909
 23. 1023, 11, 1909
 24. 1024, 11, 1909
 25. 1025, 11, 1909
 26. 1026, 11, 1909
 27. 1027, 11, 1909
 28. 1028, 11, 1909
 29. 1029, 11, 1909
 30. 1030, 11, 1909

FOR STATE HEALTH DEPT.

05460

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05453

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print) <i>Raymond L. Baxter</i>		2a. DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> 4-26 1969		2b. HOUR <i>69</i>
3. SEX <i>M</i>	4. RACE <i>W</i>	5. DATE OF BIRTH <i>5 Jan 21</i>	6. AGE (In years last birthday) <i>48</i> YRS.	2c. DATE PRONOUNCED DEAD <i>April</i> Day <i>27</i> Year <i>69</i>
7a. BIRTHPLACE (State or foreign country) <i>Payette Co. IDAHO</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <i>Hartford</i>
10. CITY OR TOWN OF DEATH <i>Hartford</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Chesapeake Bay U.S. Army</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>U.S. Army</i>
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>		13b. COUNTY <i>Hartford</i>	13c. CITY OR TOWN <i>Hartford</i>	13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
14. FATHER'S NAME <i>Deceased LYLE</i>		15. MOTHER'S MAIDEN NAME <i>ALMA J BAXTER</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? <i>yes</i>		16b. SOCIAL SECURITY NO. <i>1941-1962 469-28-9505</i>		17. INFORMANT <i>Erverda F. BAXTER</i>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Asphyxia due to Drowning</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>8300</i> (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year <i>4-26 1969</i>	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <i>Fell off boat</i>	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>Chesapeake Bay</i>	21f. LOCATION Street or R.F.D. No. <i>Hartford</i> City or Town <i>Hartford</i> County <i>Hartford</i> State <i>Md.</i>	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE <i>Gerald P Palmer</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED <i>4-27-69</i>
EXAMINER'S NAME (Type) <i>Gerald P Palmer MD</i>		ADDRESS (Street, city, town, or county) <i>Bel Air, Md.</i>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	23b. DATE <i>30 April 69</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Post Cemetery</i>	23d. LOCATION (City or Town) (County) (State) <i>Aberdeen Proving Ground, Md.</i>	
24. FUNERAL DIRECTOR <i>Walter McCoubert Sr.</i>		25a. REC'D BY REGISTRAR <i>MAY 2 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>

2. *Desmodium illinoense*

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										05454		
05461 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
MEDICAL EXAMINER'S CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or Print) EDWARD			First L. Middle BLANTON Last			2a. DATE KNOWN <input checked="" type="checkbox"/> OF ESTI- DEATH MATED <input type="checkbox"/> April 3 1969			2b. HOUR M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH		6. AGE (In years last birthday) 38 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) VA			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Harford			
10. CITY OR TOWN OF DEATH Forest Hill				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Pleasantville Road				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland				13b. COUNTY Harford		13c. CITY OR TOWN Forest Hill		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER Pleasantville Road		
14. FATHER'S NAME First William L. Middle BLANTON Last						15. MOTHER'S MAIDEN NAME First MARY Lee Middle JONES Last						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes				16b. SOCIAL SECURITY NO. WELL		17. INFORMANT JAMES BLANTON				ADDRESS Beltsville md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 890 X (b) Carbon monoxide DUE TO, OR AS A CONSEQUENCE OF (c) Conflagration										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year 1:55 P.M. 4-3 19 69				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Found in burning house				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) House				21f. LOCATION Street or R.F.D. No. Pleasantville Rd. City or Town Forest Hill, County Harford, State Md.				
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE Charles S. Springate				M.D.				22b. DATE SIGNED 4-6-69				
EXAMINER'S NAME (Type) Charles S. Springate, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
				ADDRESS (Street, city, town, or county)								
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL				23b. DATE 4-8-69		23c. NAME OF CEMETERY OR CREMATORY CANAWA			23d. LOCATION (City or Town) LACROSSE (County) VA. (State)			
24. FUNERAL DIRECTOR Samuel H. Haczorowski						ADDRESS 3525 Forest St		25a. REC'D BY REGISTRAR g Charles Judge		25b. REGISTRAR'S SIGNATURE		
						DATE APR 7 1969						

TOP STATE
HEALTH DEPT

05407

DEPARTMENT OF HEALTH
MEDICAL EXAMINER'S CERTIFICATE OF DEATH



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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon plates, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05462		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				05455	
1. DECEASED-NAME (Type or print) <i>First</i> <i>Ross</i> <i>Middle</i> <i>Hampton</i> <i>Last</i> <i>Boddy</i>				2a. DATE OF DEATH Month <i>4</i> Day <i>17</i> Year <i>69</i>		2b. HOUR <i>11:05</i> M	
3. SEX <i>Male</i>		4. RACE <i>Colored</i>		5. DATE OF BIRTH <i>March 28, 1918</i>		6. AGE (In years last birthday) <i>51</i> YRS.	
7a. BIRTHPLACE (State or foreign country) <i>Mo</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Hartford</i> Md.	
10. CITY OR TOWN OF DEATH <i>Havre de Grace</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Hartford Memorial</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Steel Labor</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Construction Co.</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution; admission) STATE <i>Md</i>		13b. COUNTY <i>Cecil</i>		13c. CITY OR TOWN <i>Port Deposit</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME <i>First</i> <i>Morris</i> <i>Middle</i> <i>Boddy</i> <i>Last</i> <i>Jane</i>		15. MOTHER'S MAIDEN NAME <i>First</i> <i>Jane</i> <i>Middle</i> <i>Jones</i> <i>Last</i> <i>Jones</i>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown) <i>no</i> (If yes give war or dates of service) <i>-</i>			
16b. SOCIAL SECURITY NO. <i>218-07-2096</i>		17. INFORMANT <i>Mrs. Henrietta E. Boddy, Port Deposit, Md.</i> Address <i>43 Granite Ave.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Diabetes mellitus & hypoglycemia</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Confluent lower lobe pneumonia, bilateral</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>3 days</i> 2509							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>acute pancreatitis</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>yes</i>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>4-9</i> , 19 <i>69</i> , to <i>4-17</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>4-16</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>George Starobay MD</i>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <i>4/17/69</i>	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>4-23-69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Zion A.M.E. Cem.</i>		23d. LOCATION (City or Town) (County) (State) <i>Conowingo, Cecil, Md.</i>	
24. FUNERAL DIRECTOR <i>Otelia J. Bullock</i>				25a. REC'D BY REGISTRAR <i>APR 23 1969</i>		25b. REGISTRAR'S SIGNATURE <i>William J. Judge</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove tabular pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05463		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				05456					
1. DECEASED-NAME (Type or print) GEORGE			First Middle Last B. BROWN		2a. DATE OF DEATH Month 6 Day 1969			2b. HOUR P 1935 M			
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH 12 APRIL 1922		6. AGE (In years last birthday) 46 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS. HOURS 0 MIN 0	
7a. BIRTHPLACE (State or foreign country) S. CAROLINA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH HARFORD			Md.		
10. CITY OR TOWN OF DEATH ABERDEEN		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) US KIRK ARMY HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Soldier		12b. KIND OF BUSINESS OR INDUSTRY U.S. Army					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MD.		13b. COUNTY HARFORD		13c. CITY OR TOWN EDGEWOOD		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 621 LACEWOOD DRIVE			
14. FATHER'S NAME First Middle Last Unknown			15. MOTHER'S MAIDEN NAME First Middle Last Unknown								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes give war or dates of service) Yes		16b. SOCIAL SECURITY NO. 250-10-8423		17. INFORMANT Kathy E. Brown,			Address Edgewood, Maryland				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE; GASTROINTESTINAL BLEEDING DUE TO, OR AS A CONSEQUENCE OF (b) METASTATIC CARCINOMA FROM ESOPHAGUS DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 150 x										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 23 Hours 7 Months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (X) (this hospital) attended the deceased from 2030 hr, 4/5, 19 69 , to 1935-4/6, 19 69 , that (I) (we) last saw the deceased alive on 1935 hr, 4/6 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Michael Freshman					22c. DATE SIGNED 4/6/69			22d. PHYSICIAN'S NAME (Type) MICHAEL FRESHMAN, CPT, MC			
22e. ADDRESS US Kirk Army Hosp, Aberdeen PG, Md.											
23a. BURIAL, CREMATION, REMOVAL (Type) Burial		23b. DATE 9 April 69		23c. NAME OF CEMETERY OR CREMATORY Post Cemetery			23d. LOCATION (City or Town) (County) (State) Aberdeen Proving Ground, Md.				
24. FUNERAL DIRECTOR Tarring Funeral Home				25a. REC'D BY REGISTRAR DATE 9 1969		25b. REGISTRAR'S SIGNATURE Charles Judge					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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05464		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				05457					
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH		2b. HOUR	
G A C T A N A						C A R C I R I C R I		Month Day Year APRIL 15 1969		7 A M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR * MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
FEMALE		white		May 17, 1886		82 YRS.					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Italy		U.S.A				HARFORD					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
HARFORD de GRACE		HARFORD Memorial		Housewife							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
Md		HARFORD		HARFORD de GRACE				1509 SUPERIOR ST.			
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First Middle Last	
Anthony di Lusille								Angela De Luca			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
				unk		Eugene Carciricri		1508 2nd Street St. Harford de Grace Md			
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4270 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) Congestive Heart failure Pneumonia, Asthma and old age								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2-3 days 2-3 days			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from May 10, 1958, to April 15, 1969, that (I) (we) last saw the deceased alive on April 14, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Dudley Phillips		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4/15/69					
22d. PHYSICIAN'S NAME (Type) Dudley Phillips MD		22e. ADDRESS DARLINGTON Md 21034									
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE 4/18/69		23c. NAME OF CEMETERY OR CREMATORY Harford Memorial		23d. LOCATION (City or Town) (County) (State) Harford Md					
24. FUNERAL DIRECTOR James Earl Ray		ADDRESS Harford de Grace Md		25a. REC'D BY REGISTRAR DATE APR 22 1969		25b. REGISTRAR'S SIGNATURE William A. Judge					

UNITED STATES OF AMERICA

Handwritten notes and signatures, including "J. Edgar Hoover" and "F. B. I.", are visible across the page. The text is mirrored and appears to be bleed-through from the reverse side of the document.

CERTIFICATE OF DEATH

05465

05458

1. DECEASED-NAME (Type or print) CARL			First Middle Last			2a. DATE OF DEATH Month Apr Day 17 Year 69			2b. HOUR 0415aM		
3. SEX Male			4. RACE Caucasion			5. DATE OF BIRTH 17 Nov 1907			6. AGE (In years last birthday) 61 YRS.		
7a. BIRTHPLACE (State or foreign country) Virginia			7b. CITIZEN OF WHAT COUNTRY? United States			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Harford		
10. CITY OR TOWN OF DEATH APG, Md.			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) US Kirk Army Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) US Army Med. Tech.			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Harford			13c. CITY OR TOWN Edgewood			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
13e. STREET AND NUMBER 9 Edgewood Road			14. FATHER'S NAME First Pete r Middle -- Last Countiss			15. MOTHER'S MAIDEN NAME First Cora Middle -- Last Swindal			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown Yes (If yes give war or dates of service) WW 11		
16b. SOCIAL SECURITY NO. 226-22-9042			17. INFORMANT Alice G. (Wife)			Address 9 Edgewood Road, Edgewood Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 2500 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Multiple Traumatic Injuries DUE TO, OR AS A CONSEQUENCE OF (c) Diabetic Keto Acidosis									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 14 Hours 14 Hours		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. 1430 pm Month Apr Day 18 Year 69 P.M.			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Automobile Accident					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) Street			21f. LOCATION Street or R.F.D. No. City or Town County State Edgewood Harford Md.					
22a. I certify that (I) (this hospital) attended the deceased from 16 Apr , 19 69 , to 17 Apr , 19 69 , that (I) (we) last saw the deceased alive on 17 Apr , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Daniel Polsky</i>									22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (Type) Daniel Polsky, CPT, MC									22e. ADDRESS US Kirk Army Hospital, APG, Md. 21005		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE April 21, 1969			23c. NAME OF CEMETERY OR CREMATORY Aberdeen Proving Ground			23d. LOCATION (City or Town) (County) (State) APG Harford Md		
24. FUNERAL DIRECTOR Howard K. McComas & Son, Abingdon, Md.						25a. REC'D BY REGISTRAR DATE APR 21 1969			25b. REGISTRAR'S SIGNATURE <i>William J. Judge</i>		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

05465

CARL

QUESTIONS

APR 17 1954

Question

Yes

United States

Yes

Is this your husband?

Yes, Sir.

London

England

Country

Page

Mar 11

1928-52-2017

Alfred G. (A.G.)

Charles Albert

Is this your husband?

Is this

Is this your husband?

Is this

1930

1910

Automobile accident

Is this

Is this

United States, City, No

Is this your husband? Yes, Sir.

Original

Received by Special Agent, Washington, D.C.

FOR STATE
HEALTH DEPT.

05466

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05459

1. DECEASED-NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> Missing 4/15/69M		2b. HOUR	
FRANCIS		C.		COX							
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (in years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year	
Male	White	June 18, 1918		50 YRS.						April Day 26 Year 19 69	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				2d. HOUR	
Maryland		USA				Harford				2:00p	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
Penningtons		Penningtons - Chesapeake Bay		General Contractor							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER			
Md.		Balto.		Balto.				705 Wampler Road			
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First Middle Last	
Edward		G.		Cox				Rose		T. Gutberlet	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO. (If yes give year or dates of service)		17. INFORMANT		ADDRESS					
Yes		WW 2		213-07-5649		Mr. James W. Cox, Sr.		1106 Stevenson Lane #4			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Probably drowned</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>984X</u> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 4 2 2 19 69				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <u>Probably drowned</u>			
21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <u>Water</u>				21f. LOCATION Street or R.F.D. No. City or Town County State <u>Found: Penningtons-Chesapeake Bay, Harford</u>			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/>											
ACTUAL SIGNATURE <u>Edward F. Wilson</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>				April 26, 1969			
EDWARD F. WILSON, M.D.				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>				ADDRESS (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		5/1/69.		Belair Memorial Cemetery		Belair, Md.					
24. FUNERAL DIRECTOR						ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Leonard J. Ruck, Inc. Balto. Md. 21214								DATE MAY 1 1969		<u>James J. J...</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
JAMES ALEXANDER CURRIER						Month Day Year		3:55 A M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS		
MALE		WHITE		APRIL 30, 1886		82 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
MD		U.S.A				HARFORD		Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
HAYRE DE GRACE			630 OTSEGO ST.			RETIRED - POSTMASTER		MAIL		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
MD			HARFORD		HAYRE DE GRACE		YES		825 MARKET, ST.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
OLIVER R. CURRIER			EMMA J. CRAWFORD							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT		Address			
			220-44-4257		OLIVER M. CURRIER		8005 MARKET, ST. HAYRE DE GRACE MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) 4109 Coronary Occlusion										
DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
(b) Cardiac Ischemic Disease										
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 10-8, 1968, to 4-7-1969, that (I) (we) last saw the deceased alive on 4-7-1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE					DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
AL LEWIS MD										
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS					
AL LEWIS MD					Hayre de Grace MD					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
BURIAL		APRIL 10, 1969		WESLEYAN CHAPEL		HARFORD CO. MD				
24. FUNERAL DIRECTOR					ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
R. Madison Mitchell					HAYRE DE GRACE MD		APR 10 1969		John L. Judge	

05467

CERTIFICATE OF DEATH

THIS IS TO CERTIFY THAT THE ABOVE NAMED DECEASED

WAS DECEASED AT THE PLACE AND ON THE DATE ABOVE STATED

AND THAT THE DECEASED WAS AT THE TIME OF DEATH

IN THE FULL POSSESSION OF HIS MIND AND

WAS NOT AT THE TIME OF DEATH

UNDER THE INFLUENCE OF ANY DRUGS OR

OTHER SUBSTANCES WHICH WOULD

RENDER HIM INCAPABLE OF MAKING

A RATIONAL JUDGMENT AS TO HIS

WILLS AND AS TO THE DISPOSITION

OF HIS ESTATE AND AS TO THE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED NAME (Type or print) John Bertha L. Day			2a. DATE OF DEATH 4 Month - 25 Day 1969			2b. HOUR 7:20 A M				
3. SEX Female		4. RACE White		5. DATE OF BIRTH 2-20-94		6. AGE (In years last birthday) 75 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) N.C.		7b. CITIZEN OF WHAT COUNTRY? USA		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Harford Md.				
10. CITY OR TOWN OF DEATH Havre-de-Grace			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Citizens Nsg. Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Practical Nurse			12b. KIND OF BUSINESS OR INDUSTRY Hospital	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.			13b. COUNTY Harford		13c. CITY OR TOWN Aberdeen		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER P.O. Box 3251	
14. FATHER'S NAME First Middle Last Troye Blevins (D)			15. MOTHER'S MAIDEN NAME First Middle Last Cynthia A. Caudill (D)							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown) No			16b. SOCIAL SECURITY NO. 213-12-2706		17. INFORMANT Address Admission Record - Pt's chart					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> 1560 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Malnutrition</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cancer of Gallbladder</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes Weeks Years	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 1969			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 1B.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from April 1969, to 4/25/69, that (I) (we) last saw the deceased alive on 4/18/69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE S. Leyte-Vidal					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4/25/69			
22d. PHYSICIAN'S NAME (Type) S. LEYTE-VIDAL					22e. ADDRESS 114 W. BEL AIR AVE. ABERDEEN, MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 28 April 69		23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens			23d. LOCATION (City or Town) (County) (State) Bel Air, (Harford Co.) Md.			
24. FUNERAL DIRECTOR Tarring Funeral Home Aberdeen, Md. 21001					25a. REC'D BY REGISTRAR DATE APR 29 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			

05248

DEPARTMENT OF DEATH

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[Large block of very faint, illegible text, possibly a narrative or detailed report]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

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VR A15-14
45M - 11-69

MARYLAND STATE DEPARTMENT OF HEALTH				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201							
05469				CERTIFICATE OF DEATH				05462			
1. DECEASED-NAME (Type or print)		First Middle Last		2a. DATE OF DEATH		2b. HOUR					
Eva		Elizabeth Denham		Month 4 Day 19 Year 69		6 PM					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)					
Female		White		SEPT. 28, 1898		80 YRS.					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Md		U.S.A.				Harford Md.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY					
Harford		Harford Memorial Hospital		313 So Washington St		HOME					
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>					
Md		Harford		Harford		313 So Washington					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.					
First Middle Last		First Middle Last				213-48-0851					
SAMUEL J. McOTT		MARTHA H. SCARBOROUGH									
17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					
G. ARNOLD PFAFFENBACH		PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4409 Arteriosclerosis - OLD AGE									
Address		DUE TO, OR AS A CONSEQUENCE OF		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
HARFORD MD		(b) DUE TO, OR AS A CONSEQUENCE OF									
		(c)									
		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 3-27-1969, to 4-19-1969, that (I) (we) last saw the deceased alive on 4-19-1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE		22c. DATE SIGNED							
		G. Arnold Pfaffenbach		4-20-69							
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS		23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE					
				BURIAL		APR. 22, 1969					
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR					
DARLINGTON CEM.		HARFORD CO. MD		R. Madison Mitchell		APR 23 1969					
25b. REGISTRAR'S SIGNATURE		25c. ADDRESS		25d. REGISTRAR'S SIGNATURE		25e. ADDRESS					
Charles Judge		HARFORD CO. MD									

1. [illegible]
2. [illegible]
3. [illegible]
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95. [illegible]
96. [illegible]
97. [illegible]
98. [illegible]
99. [illegible]
100. [illegible]

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05470		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				05463	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or Print)		First	Middle	Last	2a. DATE KNOWN OF DEATH		2b. HOUR
Edwards Nelson Wade Edwards					Month Day Year		3:30 P.M.
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	2c. DATE PRONOUNCED DEAD	2d. HOUR
M	C	4/15/01	67 YRS			Month Day Year	3:30 P.M.
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
Washington, D.C.		USA				Harford Md.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Harford, Md.		Harford Memorial Hospital					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. STREET AND NUMBER	
D.C.				Washington		1031 Euclid St	
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME		First Middle Last
John A. Edwards, Sr.					Alice Wood		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
yes				John A. Edwards, Jr. see # 13		Wash., D.C.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) DUE TO, OR AS A CONSEQUENCE OF (c)							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
		19					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town	County State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE		Gerald C. Palmer		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED	
EXAMINER'S NAME (Type)		Gerald C. Palmer, M.D.		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		4-14-69	
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				ADDRESS (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial		4/18/69	Harmony Mem. Park		Highland Park, Maryland		
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Robert J. Jones		1820 9th St Washington, D.C.		APR 18 1969		Charles Judge	

05420

1. The first part of the report is a general description of the project and its objectives. It includes a brief history of the project and a statement of the problem to be solved. The second part of the report is a detailed description of the methodology used in the study. This includes a description of the data collection methods, the statistical methods used for data analysis, and the experimental procedures used to test the hypotheses. The third part of the report is a discussion of the results of the study. This includes a description of the findings, a comparison of the results with previous studies, and a discussion of the implications of the findings. The fourth part of the report is a conclusion and a list of references. The conclusion summarizes the main findings of the study and provides a final statement on the project. The references list the sources of information used in the study.

2. The first part of the report is a general description of the project and its objectives. It includes a brief history of the project and a statement of the problem to be solved. The second part of the report is a detailed description of the methodology used in the study. This includes a description of the data collection methods, the statistical methods used for data analysis, and the experimental procedures used to test the hypotheses. The third part of the report is a discussion of the results of the study. This includes a description of the findings, a comparison of the results with previous studies, and a discussion of the implications of the findings. The fourth part of the report is a conclusion and a list of references. The conclusion summarizes the main findings of the study and provides a final statement on the project. The references list the sources of information used in the study.

3. The first part of the report is a general description of the project and its objectives. It includes a brief history of the project and a statement of the problem to be solved. The second part of the report is a detailed description of the methodology used in the study. This includes a description of the data collection methods, the statistical methods used for data analysis, and the experimental procedures used to test the hypotheses. The third part of the report is a discussion of the results of the study. This includes a description of the findings, a comparison of the results with previous studies, and a discussion of the implications of the findings. The fourth part of the report is a conclusion and a list of references. The conclusion summarizes the main findings of the study and provides a final statement on the project. The references list the sources of information used in the study.

4. The first part of the report is a general description of the project and its objectives. It includes a brief history of the project and a statement of the problem to be solved. The second part of the report is a detailed description of the methodology used in the study. This includes a description of the data collection methods, the statistical methods used for data analysis, and the experimental procedures used to test the hypotheses. The third part of the report is a discussion of the results of the study. This includes a description of the findings, a comparison of the results with previous studies, and a discussion of the implications of the findings. The fourth part of the report is a conclusion and a list of references. The conclusion summarizes the main findings of the study and provides a final statement on the project. The references list the sources of information used in the study.

5. The first part of the report is a general description of the project and its objectives. It includes a brief history of the project and a statement of the problem to be solved. The second part of the report is a detailed description of the methodology used in the study. This includes a description of the data collection methods, the statistical methods used for data analysis, and the experimental procedures used to test the hypotheses. The third part of the report is a discussion of the results of the study. This includes a description of the findings, a comparison of the results with previous studies, and a discussion of the implications of the findings. The fourth part of the report is a conclusion and a list of references. The conclusion summarizes the main findings of the study and provides a final statement on the project. The references list the sources of information used in the study.

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VR A15
45M - 139

05471		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				05464	
1. DECEASED-NAME (Type or print) <i>Annie Mabel Elliott</i>		First Middle Last		2a. DATE OF DEATH <i>April 23 1969</i>		2b. HOUR <i>4 A</i> M	
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>31 March 1894</i>		6. AGE (In years last birthday) <i>75</i> YRS.	
7a. BIRTHPLACE (State or foreign country) <i>Md</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Harford</i>	
10. CITY OR TOWN OF DEATH <i>Harre de Grace</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Harford Memorial Hosp.</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Home</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md</i>		13b. COUNTY <i>Harford</i>		13c. CITY OR TOWN <i>Aberdeen</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME <i>John Boyd (D)</i>		First Middle Last		15. MOTHER'S MAIDEN NAME <i>Sophia A. Sampson (D)</i>		First Middle Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <i>220-09-0059</i>		17. INFORMANT Address <i>Arthur B. Elliott, Aberdeen, Maryland</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>486X</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Pneumonia bilob.</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>30 hours.</i>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>30 hours.</i>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>CVA, HCV D decomp.</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>4-23</i> , 19 <i>69</i> , to <i>4-25</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>4-25</i> 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>A. Mezei</i>		22c. DATE SIGNED <i>26 April 1969</i>		22d. PHYSICIAN'S NAME (Type) <i>I.L. Mezei, M.D.</i>			
22e. ADDRESS <i>Havre de Grace, Maryland</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>28 April 69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Grove Presbyterian Cemetery, Aberdeen, Maryland</i>		23d. LOCATION (City or Town) (County) (State) <i>(Aberdeen, Harford, Md.)</i>	
24. FUNERAL DIRECTOR <i>Tarring Funeral Home, Aberdeen, Md. 21001</i>		ADDRESS		25a. REC'D BY REGISTRAR <i>APR 29 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

05421

House of Representatives
Committee on Education and the Labor Force
Subcommittee on Education
Hearings
on
The Status of the Nation's Schools
and
The Role of the Teacher
in
The Education of the Nation's Youth
in
The Year 1980
and
The Role of the Teacher
in
The Education of the Nation's Youth
in
The Year 1980

U.S. House of Representatives
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in
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05472

CERTIFICATE OF DEATH

05465

1. DECEASED-NAME (Type or print) <i>Blanche COX Etter</i>			2a. DATE OF DEATH Month <i>APRIL</i> Day <i>7</i> Year <i>1969</i>			2b. HOUR <i>1:40 P</i> M					
3. SEX <i>FEMALE</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>10-8-1883</i>		6. AGE (In years last birthday) <i>85</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <i>Virginia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>HARFORD</i> Md.					
10. CITY OR TOWN OF DEATH <i>Rising Sun</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Harford Memorial Hospital</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Housewife</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>OWN Home</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>md.</i>			13b. COUNTY <i>Cecil</i>		13c. CITY OR TOWN <i>Rising Sun</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>R. F. D.</i>		
14. FATHER'S NAME First <i>McLville</i> Middle <i>COX</i> Last <i>COX</i>			15. MOTHER'S MAIDEN NAME First <i>Martha</i> Middle <i>FULTON</i> Last <i>FULTON</i>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>NO</i>			16b. SOCIAL SECURITY NO. <i>420-34-675</i>			16c. INFORMANT <i>Mr. Boyd C. Etter</i>			Address <i>Rising Sun, Md.</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Peritonitis</i> <i>531.1</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Perforated pyloric ulcer</i> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>6 days</i> <i>6 days</i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>Renal insufficiency</i>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 1B.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>4/1/69</i> , 19 <i>69</i> , to <i>4/7/69</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>4/7/69</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>A.W. Grigoleit</i>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <i>4/7/69</i>		
22d. PHYSICIAN'S NAME (Type) <i>A.W. GRIGOLEIT</i>						22e. ADDRESS <i>HAIRE de GRACE</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE <i>4-10-69</i>			23c. NAME OF CEMETERY OR CREMATORY <i>Brookview Cem</i>			23d. LOCATION (City or Town) (County) (State) <i>Rising Sun Cecil Md.</i>		
24. FUNERAL DIRECTOR <i>Monroe H. Mullen</i>			ADDRESS <i>Rising Sun, Md.</i>			25a. REC'D BY REGISTRAR <i>APR 11 1969</i>			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

08473

RECEIVED BY STATE

UNITED STATES DEPARTMENT OF THE INTERIOR

[Faint, mostly illegible text and markings, possibly bleed-through from the reverse side of the page.]

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VR 11-1-69
45M 11-1-69

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
05473					05466				
1. DECEASED-NAME (Type or print) <u>Edgar Martin Foley</u>					2a. DATE OF DEATH Month <u>4</u> Day <u>30</u> Year <u>1969</u>				
3. SEX <u>Male</u>		4. RACE <u>White</u>		5. DATE OF BIRTH <u>MAR. 15, 1896</u>			6. AGE (In years last birthday) <u>73</u>		2b. HOUR <u>8:20 PM</u>
7a. BIRTHPLACE (State or foreign country) <u>W. Va.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>HARFORD</u>			
10. CITY OR TOWN OF DEATH <u>Harre-de-Grace</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Harre-de-Grace Memorial Hospital</u>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>DENTIST</u>			12b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>	
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <u>Md.</u>		13b. COUNTY <u>Harford</u>		13c. CITY OR TOWN <u>Harre-de-Grace</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <u>554 Franklin St</u>	
14. FATHER'S NAME First <u>John F.</u> Middle <u>Foley</u> Last <u>Foley</u>			15. MOTHER'S MAIDEN NAME First <u>Helen</u> Middle <u>Gunning</u> Last <u>Gunning</u>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <u>YES</u>		16b. SOCIAL SECURITY NO. <u>212-18-4227</u>		17. INFORMANT <u>Mrs. Geraldine S. Foley</u>		Address <u>554 Franklin St. Harre-de-Grace, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized carcinomatosis,</u> DUE TO, OR AS A CONSEQUENCE OF <u>Primary Cancer</u> (b) <u>A.S.C.V.D.</u> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>1579</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION <u>4-29-69</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Obstructive jaundice</u>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>4-12</u> , 19 <u>69</u> , to <u>4-30</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>4-30</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Henry H. Kwak</u>				DEGREE <u>M.D.</u> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>4-30-69</u>			
22d. PHYSICIAN'S NAME (Type) <u>HENRY H. KWAK, M.D.</u>				22e. ADDRESS <u>608 S. UNION AVE. HARRE-DE-GRAVE</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		23b. DATE <u>MAY 3, 1969</u>		23c. NAME OF CEMETERY OR CREMATORY <u>ST. FRANCIS CH. CEM.</u>		23d. LOCATION (City or Town) (County) (State) <u>ABINGDON HARFORD MD.</u>			
24. FUNERAL DIRECTOR <u>R. Madison Mitchell</u>				ADDRESS <u>HARRE-DE-GRAVE MD</u>		25a. REC'D BY REGISTRAR <u>MAY 5 1969</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

05473

CERTIFICATE OF DEATH

IN THE DISTRICT OF COLUMBIA, D.C.

[Faint, mostly illegible text, likely bleed-through from the reverse side of the document. The text appears to be a form with various fields and possibly a signature.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

05474

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

05467

1. DECEASED-NAME (Type or print) <i>Baby Girl Hittings.</i>			2a. DATE OF DEATH Month <i>Apr.</i> Day <i>3</i> Year <i>1969</i>			2b. HOUR <i>3:30</i> M.					
3. SEX <i>Female</i>		4. RACE <i>colored</i>		5. DATE OF BIRTH <i>4-3-69</i>		6. AGE (In years last birthday) YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <i>MARYLAND</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>HARFORD</i> Md.					
10. CITY OR TOWN/OF DEATH <i>HAURE de Grace</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>HARFORD Memorial Hosp.</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>none</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>none</i>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Md.</i>			13b. COUNTY <i>HARFORD</i>		13c. CITY OR TOWN <i>Aberdeen</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>8 Fenway Street</i>		
14. FATHER'S NAME First <i>Harry L.</i> Middle <i>Simpson</i> Last <i>Simpson</i>			15. MOTHER'S MAIDEN NAME First <i>Sharon</i> Middle <i>Gittings</i> Last <i>Gittings</i>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <i>no</i> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <i>_____</i>		17. INFORMANT <i>Mrs Eva Simpson, Aberdeen, Md.</i> Address						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Prematurity</i> <i>7701</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) <i>Premature Separation of the Placenta</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>4/3</i> , 19 <i>69</i> , to <i>4/3</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>4-3-</i> 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>George T. Stansbury, M.D.</i>			22c. DATE SIGNED <i>April 3, 1969</i>			22d. PHYSICIAN'S NAME (Type) <i>George T. Stansbury, M.D.</i>					
22e. ADDRESS <i>569 Revolution Street Haure de Grace Maryland</i>											
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE <i>April 5, 1969</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Union United Meth Cem</i>		23d. LOCATION (City or Town) (County) (State) <i>Aberdeen Harford, Md.</i>				
24. FUNERAL DIRECTOR <i>Othello J. Bullock, Haure de Grace, Md.</i>			25a. REC'D BY REGISTRAR <i>APR 8 1969</i>			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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05475		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				05468	
CERTIFICATE OF DEATH							
1. DECEASED-NAME (Type or print)		First Mabel		Middle Gorrell		Last April	
3. SEX Female		4. RACE White		5. DATE OF BIRTH May 19, 1902		6. AGE (In years last birthday) 66 YRS.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Harford	
10. CITY OR TOWN OF DEATH HAURE DE GRACE		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Harford Memorial Hosp		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Penna		13b. COUNTY York		13c. CITY OR TOWN Delta		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Milford		Middle M.		Last Carr (D)		15. MOTHER'S MAIDEN NAME First Ella	
Middle Porter		Last (D)					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO. 179-0906538-B		17. INFORMANT Wilson Gorrell, Delta, Penna.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis, Massive 4339 DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerosis Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Cardiac Standstill							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 19 to 4-29, 1969, that (I) (we) lost saw the deceased alive on 4-29, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Dante U. Monakil, M.D.		DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4-29-69	
22d. PHYSICIAN'S NAME (Type) DANTE U. MONAKIL, M.D.		22e. ADDRESS 511 N. Union Ave, Harford, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 2 May 69		23c. NAME OF CEMETERY OR CREMATORY Slate Ridge Cemetery		23d. LOCATION (City or Town) (County) (State) Delta, Penna.	
24. FUNERAL DIRECTOR Delata Macaugh Sr.		ADDRESS Tarring Funeral Home Aberdeen, Md.		25a. REC'D BY REGISTRAR MAY 2 1969		25b. REGISTRAR'S SIGNATURE Charles Judge	

05475

UNITED STATES DEPARTMENT OF AGRICULTURE

OFFICE OF THE SECRETARY

WASHINGTON, D. C.

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TO HOSPITAL & ATTENDING PHYSICIAN: The law requires that the death certificate be executed within _____ hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
05476 CERTIFICATE OF DEATH 05469									
1. DECEASED-NAME (Type or print)			First <u>Wellington</u> Middle <u>Crawford</u> Last <u>Reid</u>			2a. DATE OF DEATH Month <u>4</u> Day <u>27</u> Year <u>69</u>			2b. HOUR <u>7:10</u> A <u>M</u>
3. SEX <u>Female</u>		4. RACE <u>Caucasian</u>		5. DATE OF BIRTH <u>April 27, 1882</u>		6. AGE (In years last birthday) <u>87</u> YRS.		IF UNDER 1 YEAR MONTHS <u>0</u> DAYS <u>0</u> IF UNDER 24 HRS. HOURS <u>0</u> MIN <u>0</u>	
7a. BIRTHPLACE (State or foreign country) <u>Nor. Carolina</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Harford</u> Md.			
10. CITY OR TOWN OF DEATH <u>Havre de Grace</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Citizens Nursing Home</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Housewife</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Homemaker</u>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Maryland</u>		13b. COUNTY <u>Harford</u>		13c. CITY OR TOWN <u>Bel Air</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <u>West Wheel Road</u> <u>McCormack Lane</u>	
14. FATHER'S NAME First <u>William C.</u> Middle <u>Reid</u> Last <u></u>			15. MOTHER'S MAIDEN NAME First <u>Cornelia</u> Middle <u>Thwaite</u> Last <u></u>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service) <u></u>			16b. SOCIAL SECURITY NO. <u>221-07-5098</u>		17. INFORMANT (Nephew 838-9203) <u>Archer</u> Address <u>Archer Bldg. - Courtland St. Bel Air, Maryland 21014</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4132</u> <u>K.C.V.D.</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u></u> (b) <u></u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u></u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. <u>19</u> Month <u>4</u> Day <u>27</u> Year <u>69</u> P.M. <u></u>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. <u></u> City or Town <u></u> County <u></u> State <u></u>				
22a. I certify that (I) (this hospital) attended the deceased from <u></u> , 19 <u></u> , to <u></u> , 19 <u></u> , that (I) (we) lost saw the deceased alive on <u></u> , 19 <u></u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Dr. Lajos Mezei</u>					DEGREE <u></u> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>April 28, 1969</u>		
22d. PHYSICIAN'S NAME (Type) <u>Dr. Lajos Mezei</u>					22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE <u>April 29, 1969</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Louisa Park Cemetery</u>		23d. LOCATION (City or Town) <u>Baltimore, Maryland</u> (County) <u></u> (State) <u></u>			
24. FUNERAL DIRECTOR <u>Joseph William Foster</u> <u>Wilbronding & Williams St. Bel Air, Maryland 21014</u>					25a. REC'D BY REGISTRAR <u>APR 29 1969</u> DATE		25b. REGISTRAR'S SIGNATURE <u>James J. Judge</u>		

UNITED STATES DEPARTMENT OF JUSTICE

37820

DATE: 10-1-57

FILE NO.

DATE

BY

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS-100. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

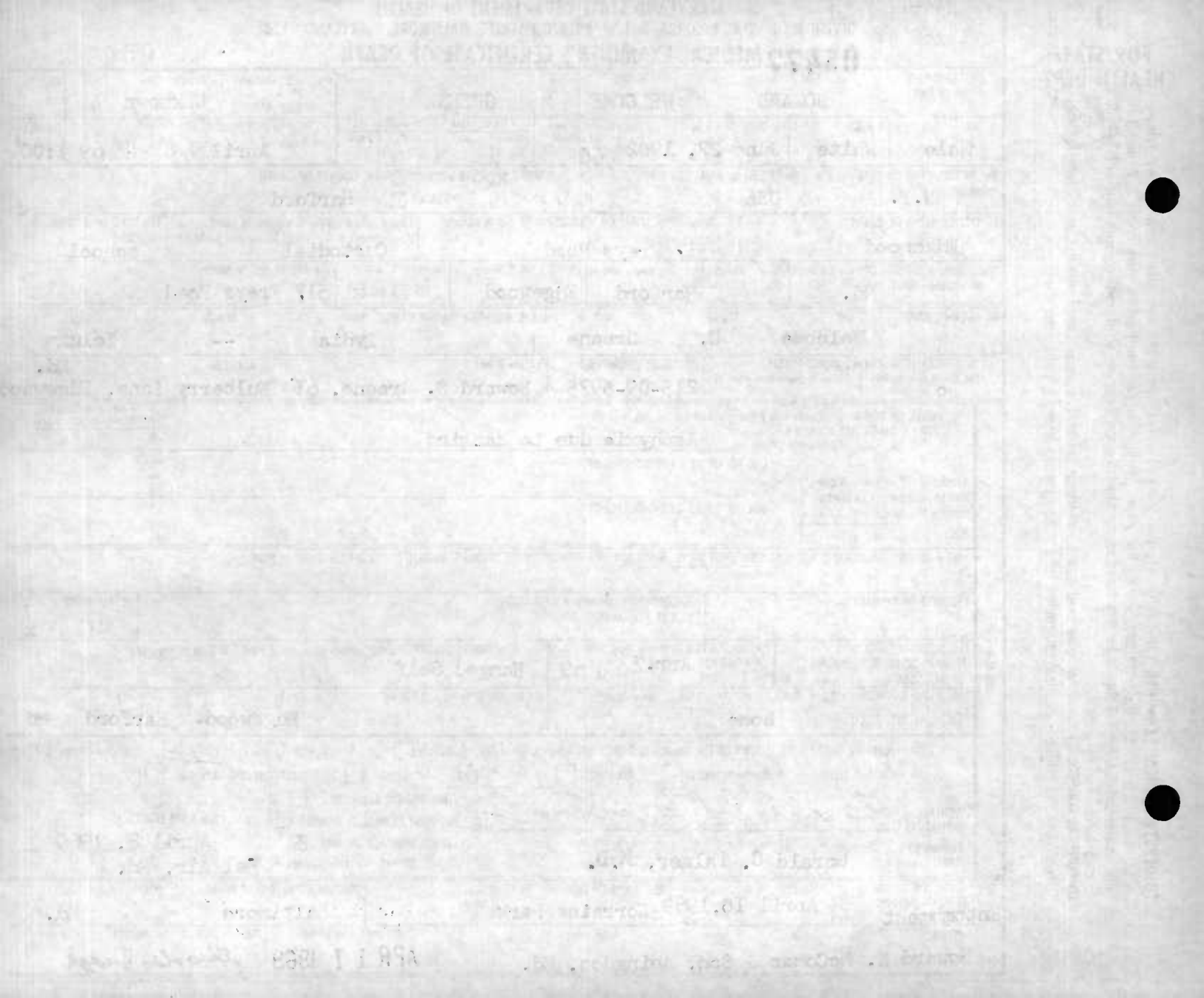
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05470

1. DECEASED-NAME (Type or Print)			First HOWARD			Middle WELCOME			Last GREENE			2a. DATE KNOWN OF ESTI- DEATH MATED <input type="checkbox"/> Unknown			2b. HOUR 19		
3. SEX Male		4. RACE White		5. DATE OF BIRTH June 27, 1902		6. AGE (In years last birthday) 66 YRS.		IF UNDER 1 YEAR MONTHS 0		IF UNDER 24 HRS. HOURS 0		2c. DATE PRONOUNCED DEAD Month April Day 8 Year 1969		2d. HOUR 1:00 P.M.			
7a. BIRTHPLACE (State or foreign country) N.Y.				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH Harford					
10. CITY OR TOWN OF DEATH Edgewood				11. NAME OF HOSPITAL OR INSTITUTION (If nat in hospital give street address) 517 Freys Road				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Custodial				12b. KIND OF BUSINESS OR INDUSTRY school					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.				13b. COUNTY Harford		13c. CITY OR TOWN Edgewood		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 517 Freys Road							
14. FATHER'S NAME First Welcome				Middle C.		Last Greene		15. MOTHER'S MAIDEN NAME First Lydia				Middle --		Last Kelump			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 215-09-5975		17. INFORMANT ADDRESS Howard G. Greene, 614 Mulberry Lane, Edgewood Md.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia due to hanging DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. Apr. 7 19 69 P.M.				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Hanged Self									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) home				21f. LOCATION Street or R.F.D. No. Edgewood				City or Town Harford		County Md.			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE Gerald C. Palmer				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED April 8, 1969					
EXAMINER'S NAME (Type) Gerald C. Palmer, M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street, city, town, or county) Bel Air, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Entombment				23b. DATE April 10, 1969		23c. NAME OF CEMETERY OR CREMATORY Lorraine Park				23d. LOCATION (City or Town) Baltimore				County Md.			
24. FUNERAL DIRECTOR Howard K. McComas & Son, Abingdon, Md.								ADDRESS		25a. REC'D BY REGISTRAR DATE APR 11 1969		25b. REGISTRAR'S SIGNATURE J. Charles Judge					



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05478

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05471

1. DECEASED-NAME (Type or Print) Rose Ella Hamilton			2a. DATE KNOWN OF DEATH <input type="checkbox"/> ESTIMATED <input checked="" type="checkbox"/> 4-21-69			2b. HOUR 11:30		
3. SEX F	4. RACE W	5. DATE OF BIRTH 12/7/1896	6. AGE (In years last birthday) 72	IF UNDER 1 YEAR MONTHS 0 DAYS 0	IF UNDER 24 HRS HOURS 0 MIN. 0	2c. DATE PRONOUNCED DEAD Month April Day 21 Year 1969		
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Harford		
10. CITY OR TOWN OF DEATH Bel Air		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 209 Thomas St		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md		13b. COUNTY Harford		13c. CITY OR TOWN Bel Air		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Thomas Run Rd. XXXXXXXXXXXXXXXX
14. FATHER'S NAME First John Middle Joshua Last Durham			15. MOTHER'S MAIDEN NAME First Lillie Middle Irene Last Hornberger			16. ADDRESS 2915 Putty Hill Ave. Balto. Md. 21234		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. 220-34-6109D		17. INFORMANT Grover W. Hamilton				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma Liver DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1978 (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (e)								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. _____ P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. _____		City or Town _____		County _____ State _____
22a. I certify that I took charge of the remains described above, held on death resulted from: Noturol causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined monner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion								
ACTUAL SIGNATURE Gerald C. Palmer		EXAMINER'S NAME (Type) Gerald C. Palmer, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED 4-21-69		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4/24/1969		23c. NAME OF CEMETERY OR CREMATORY Old Brick Baptist		23d. LOCATION (City or Town) (County) (State) Jarrettsville, Maryland		
24. FUNERAL DIRECTOR Charles E. Kurtz				ADDRESS 21084 Jarrettsville, Md.		25a. REC'D BY REGISTRAR APR 23 1969		25b. REGISTRAR'S SIGNATURE J Charles Judge

05432

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		John Jordan Durham	
Residence		2205-5th Avenue, Grover, W. Harrison, N.J.	
Date of Death		April 1, 1932	
Place of Death		Home	
Cause of Death		Died from unknown cause	
Manner of Death		Natural	
Age		35 years	
Sex		Male	
Race		White	
Occupation		None	
Signature of Medical Examiner		[Signature]	
Signature of Coroner		[Signature]	
Signature of Registrar		[Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

05479

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05479

1. DECEASED-NAME (Type or print) First Middle Last Sadie May Harmon			2a. DATE OF DEATH Month 4 Day 7 Year 69			2b. HOUR 10 P M					
3. SEX F		4. RACE W		5. DATE OF BIRTH May 2, 1907		6. AGE (In years last birthday) 61 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (State or foreign country) W. Va.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Harford Md.					
10. CITY OR TOWN OF DEATH Harford			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Harford Memorial			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE md			13b. COUNTY Harford			13c. CITY OR TOWN Aberdeen			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME First Middle Last Isaac Halsey			15. MOTHER'S MAIDEN NAME First Middle Last Aiminta White Lambert								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input type="checkbox"/> No, <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 236-32-0636			17. INFORMANT Carl Harman, Aberdeen, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerotic heart disease 2509 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) diabetes mellitus DUE TO, OR AS A CONSEQUENCE OF (c) generalized arteriosclerosis									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 69			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 4-5 , 19 69 , to 4-7 , 19 69 , that (I) (we) last saw the deceased alive on 4/7/69 , 19 69 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Irvin L. Wachsman						DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 4/9/69	
22d. PHYSICIAN'S NAME (Type) Irvin L. Wachsman, M.D.						22e. ADDRESS Harford, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 10 April, 69		23c. NAME OF CEMETERY OR CREMATORY St Paul Lutheran Cemetery			23d. LOCATION (City or Town) (County) (State) Aberdeen, (Harford) Md.			
24. FUNERAL DIRECTOR Tarring Funeral Home, Aberdeen, Md. 21001						25a. REC'D BY REGISTRAR APR 14 1969		25b. REGISTRAR'S SIGNATURE Charles Judge			

Item 2 Film 112
4/30/69 kkk
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
05480 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05473

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print)			First HARRY			Middle Herbert			Last HARPLE			2a. DATE KNOWN OF DEATH MATED <input type="checkbox"/> Month Day Year Unknown <input type="checkbox"/> 19			2b. HOUR M				
3. SEX Male		4. RACE White		5. DATE OF BIRTH April 23, 1897		6. AGE (In years last birthday) 71 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD Month April Day 16 Year 1969			2d. HOUR 1:30 M				
7a. BIRTHPLACE (State or foreign country) Pa.				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>				9. COUNTY OF DEATH Harford				Md.			
10. CITY OR TOWN OF DEATH Havre de Grace				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) DOA - Harford Memorial Hospital				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Laborer				12b. KIND OF BUSINESS OR INDUSTRY Restaurant							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.				13b. COUNTY Harford				13c. CITY OR TOWN Abingdon		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 4401 Pulaski Highway				Abingdon, Md.			
14. FATHER'S NAME			First John			Middle --			Last Harple			15. MOTHER'S MAIDEN NAME			First Unknown				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes				(If yes give war or dates of service) WWI				16b. SOCIAL SECURITY NO. 180-09-9995				17. INFORMANT Frederick S. Goeller				ADDRESS Abingdon, Md. 4401 Pulaski Highway			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASCV Disease 4124 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																			
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE Gerald C Palmer				M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED April 16, 1969			
EXAMINER'S NAME (Type) Gerald C. Palmer, M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street, city, town, or county) Bel Air, Md.											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial				23b. DATE Apr. 19, 1969				23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens				23d. LOCATION (City or Town) (County) (State) Bel Air Harford Md.							
24. FUNERAL DIRECTOR Howard K. McComas & Son, Abingdon, Md.								ADDRESS				25a. REC'D BY REGISTRAR DATE APR 18 1969				25b. REGISTRAR'S SIGNATURE J Charles Judge			

05480 MEDICAL EXAMINATION REPORT

DATE	TIME	LOCATION	EXAMINER
APR 11 1968	10:00 AM	Room 101	Dr. J. H. Smith
PATIENT NAME: [illegible]			
AGE: [illegible] SEX: [illegible]			
REASON FOR EXAMINATION: [illegible]			
VITAL SIGNS: [illegible]			
HEENT: [illegible]			
HEART: [illegible]			
LUNGS: [illegible]			
ABDOMEN: [illegible]			
NEUROLOGIC: [illegible]			
PSYCHIATRIC: [illegible]			
IMPRESSION: [illegible]			
RECOMMENDATION: [illegible]			
SIGNATURE: [illegible]			
DATE: [illegible]			

APR 11 1968

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

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05481

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05474

1. DECEASED-NAME (Type or Print) MARTIN		First ANDREW		Middle HAUER		Last HAUER		2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> APRIL 29 1969		2b. HOUR 1:10 P	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH JAN 1, 1899		6. AGE (In years last birthday) 70 YRS		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS. HOURS MIN 	
7a. BIRTHPLACE (State or foreign country) York Pa		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH HARFORD		2c. DATE PRONOUNCED DEAD Month MAY Day 5 Year 1969		2d. HOUR 3:30 P	
10. CITY OR TOWN OF DEATH DARLINGTON		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) RURAL-SUSQUEHANNA RIVER		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) BOAT BOWLING ALLEY		12b. KIND OF BUSINESS OR INDUSTRY Retired		13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE PENNA		13b. COUNTY YORK	
13c. CITY OR TOWN YORK		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER 823 WAYNE AVE.		14. FATHER'S NAME First W. Hauer Middle Last 		15. MOTHER'S MAIDEN NAME First Mary Jane Middle Murd's Last 		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Army	
16b. SOCIAL SECURITY NO. 210-182921		16c. VITAL INFORMANT Mrs Martin Hauer York Pa		16d. ADDRESS 		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DROWNING 8300 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ACCIDENT - BOAT TURNED OVER DUE TO, OR AS A CONSEQUENCE OF (c) 		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH INSTANT		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 	
19a. DATE OF OPERATION 		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 		20. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year 1:10 P.M. APRIL 29 1969		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) BOAT STUCK CABLE TURNED OVER	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) SUSQUEHANNA RIVER		21f. LOCATION Street or R.F.D. No. OFF SHORES LANDING RD, DARLINGTON, Md		22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		ACTUAL SIGNATURE Philip W. Heuman M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) PHILIP W. HEUMAN, M.D		22b. DATE SIGNED MAY 5, 1969		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		307 HICKORY AVE		ADDRESS (Street, city, town, or county) BEL AIR, Md 21014		23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	
23b. DATE 5/8/69		23c. NAME OF CEMETERY OR CREMATORY McRose		23d. LOCATION (City or Town) York Pa. (County) (State) 		24. FUNERAL DIRECTOR Forrest H. Hauer		ADDRESS 		25a. REC'D BY REGISTRAR MAY 8 1969	
25b. REGISTRAR'S SIGNATURE 		25c. REGISTRAR'S SIGNATURE 		25d. REGISTRAR'S SIGNATURE 		25e. REGISTRAR'S SIGNATURE 		25f. REGISTRAR'S SIGNATURE 		25g. REGISTRAR'S SIGNATURE 	

02481

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1-69

05482		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				05475				
1. DECEASED NAME (Type or print) ^{First} <u>Virginia Elizabeth</u> ^{Middle} <u>Heninger</u> ^{Last}						2a. DATE OF DEATH ^{Month} <u>4</u> ^{Day} <u>5</u> ^{Year} <u>69</u>		2b. HOUR <u>2:30</u> ^{PM}		
3. SEX <u>Female</u>		4. RACE <u>White</u>		5. DATE OF BIRTH <u>Oct. 17, 1893</u>		6. AGE (In years last birthday) <u>75</u> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN		
7a. BIRTHPLACE (State or foreign country) <u>Virginia</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>HARFORD</u> Md.				
10. CITY OR TOWN OF DEATH <u>Harrods Grace</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Harford Memorial Hospital</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Retired</u>		12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <u>Md</u>		13b. COUNTY <u>Harford</u>		13c. CITY OR TOWN <u>Harrods Grace</u>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <u>Chapel Terrace</u>		
14. FATHER'S NAME ^{First} <u>George</u> ^{Middle} <u>Washington</u> ^{Last} <u>Blakenbeck</u>		15. MOTHER'S MAIDEN NAME ^{First} <u>Mamie</u> ^{Middle} <u>Ann</u> ^{Last} <u>Wolfe</u>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16b. SOCIAL SECURITY NO. <u>Unknown</u>		17. INFORMANT <u>Thomas W. Heninger, Harrods Grace, Md</u> Address						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <u>1829</u> IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma of Uterus</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinoma of Uterus</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>5-6 pm</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <u>4-4</u> , 19 <u>68</u> , to <u>4-5</u> , 19 <u>69</u> , that (I) (we) last saw the deceased alive on <u>4/3</u> , 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Dudley Phillips</u>				DEGREE <u>MD</u> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>4/6/69</u>				
22d. PHYSICIAN'S NAME (Type) <u>Dudley Phillips</u>				22e. ADDRESS <u>Darlington Md 21034</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <u>4-8-1969</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Harrods Grace</u>		23d. LOCATION (City or Town) (County) (State) <u>Harrods Grace, Harford, Md</u>				
24. FUNERAL DIRECTOR <u>Paul J. Arthur & Son, Perryville, Md</u>				ADDRESS		25a. REC'D BY REGISTRAR <u>APR 11 1969</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 6 Film 12 5/1/69k MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
05483 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 05476												
1. DECEASED-NAME (Type or Print) First Middle Last CARL MAAG HERGET						2a. DATE KNOWN OF DEATH Month Day Year April 24, 1969			2b. HOUR M A			
3. SEX Male		4. RACE White		5. DATE OF BIRTH Jan. 24, 1913		6. AGE (In years last birthday) 55 56 RS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) Baltimore, Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH HARFORD Md.			
10. CITY OR TOWN OF DEATH Bel Air				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 916 Rockspring Ave.				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Physicist			12b. KIND OF BUSINESS OR INDUSTRY Civil Service	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.				13b. COUNTY Harford		13c. CITY OR TOWN Bel Air		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 916 Rockspring Ave. Road		
14. FATHER'S NAME First Middle Last Charles Herget				15. MOTHER'S MAIDEN NAME First Middle Last Anna Maag								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No				16b. SOCIAL SECURITY NO. 218-09-4651		17. INFORMANT (Wife 838-5305) Mrs. Jean C. Herget			ADDRESS 916 Rock Spring Road Bel Air, Maryland 21014			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 4124 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE Charles S. Springate		M.D. Charles S. Springate, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ADDRESS (Street, city, town, or county)			22b. DATE SIGNED April 24, 1969			
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE (25) April 25, 1969		23c. NAME OF CEMETERY OR CREMATORY Green Mount Cemetery			23d. LOCATION (City or Town) (County) (State) Baltimore Maryland					
24. FUNERAL DIRECTOR Joseph William Foster						ADDRESS W. Broadway & Williams St. Bel Air, Maryland 21014		25a. REC'D BY REGISTRAR DATE APR 28 1969		25b. REGISTRAR'S SIGNATURE Charles Judge		

9501 2 2 39A

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
05484		Item 7 Film Roll 4/9/69 kk						05477	
1. DECEASED-NAME (Type or print) First Middle Lost Ludmila Hladka					2a. DATE OF DEATH April Month Day 2 Year 1969			2b. HOUR M	
3. SEX Female		4. RACE White		5. DATE OF BIRTH 5 Sept 1884		6. AGE (in years lost birthday) 84 YRS.		IF UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (Country) Czechoslovakia		7b. CITIZEN OF WHAT COUNTRY? Czechoslovakia		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Harford Md.			
10. CITY OR TOWN OF DEATH Aberdeen,		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) R.D.# 1 Montreal Drive		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Harford		13c. CITY OR TOWN Aberdeen		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER R.D.# 1 Montreal Drive	
14. FATHER'S NAME First Middle Lost Florian Poledna			15. MOTHER'S MAIDEN NAME First Middle Lost Anna Fiedler						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No			16b. SOCIAL SECURITY NO. 220 54 2996 J		17. INFORMANT Frank Hladka R.D.# 1 Aberdeen, Maryland				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> <u>4109</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>CORONARY THROMBOSIS</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>ASCVD</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>MIN.</u> <u>HOURS</u> <u>YEARS.</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (o)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Leyte Vidal</u>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 2 April 69			
22d. PHYSICIAN'S NAME (Type) Leyte-Vidal Santiago M.D.				22e. ADDRESS 114 Bel Air Ave Aberdeen, Maryland 21001					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 3 April 69		23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens		23d. LOCATION (City or Town) (County) (State) Bel Air, Harford, Maryland			
24. FUNERAL DIRECTOR <u>Kenneth B. Gango</u>				Tarring Funeral Home Aberdeen, Maryland 21001		25a. REC'D BY REGISTRAR DATE APR 7 1969		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

05485

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05478

1. DECEASED-NAME (Type or print)		First <i>Lewis</i>		Middle <i>Layfield</i>		Last <i>Jackson</i>		2a. DATE OF DEATH		Month <i>4</i>		Day <i>10</i>		Year <i>69</i>		2b. HOUR <i>5:48</i>	
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>2-14-1881</i>				6. AGE (In years lost birthday) <i>88</i> YRS.		IF UNDER 1 YEAR MONTHS <i>0</i>		DAYS <i>0</i>		IF UNDER 24 HRS. HOURS <i>0</i>		MIN <i>0</i>	
7a. BIRTHPLACE (State or foreign country) <i>md</i>		7b. CITIZEN OF WHAT COUNTRY? <i>Cecil</i>		8. MARRIED WIDOWED <input checked="" type="checkbox"/>		NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Hartford</i>									
10. CITY OR TOWN OF DEATH <i>Thurde-Grace</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Hartford Memorial Hospital</i>				12a. USUAL OCCUPATION (Kind of work done during most of working life; even if retired) <i>Capital Natural</i>				12b. KIND OF BUSINESS OR INDUSTRY							
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <i>md</i>		13b. COUNTY <i>Cecil</i>		13c. CITY OR TOWN <i>Principis</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER									
14. FATHER'S NAME		First <i>Clifford</i>		Middle <i>Jackson</i>		Last <i>Jackson</i>		15. MOTHER'S MAIDEN NAME		First <i>Ellen</i>		Middle <i>Carter</i>		Last <i>Carter</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>NO</i>		16b. SOCIAL SECURITY NO. <i>214-01-7959</i>		17. INFORMANT <i>Paul J. Benson</i>		Address <i>3141 N. Ind.</i>											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Chronic Heart Failure</i> <i>4124</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Coronary Arteriosclerosis & Arterio Sclerosis - byps</i> DUE TO, OR AS A CONSEQUENCE OF (c)																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 weeks</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Gouty Arthritis</i>																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)													
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from <i>3-31, 1969</i> , to <i>4-10, 1969</i> , that (I) (we) lost saw the deceased alive on <i>4-10, 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE <i>Clarence J. Benson</i>		DEGREE		ATTENDING PHYS.		<input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>4/11/69</i>					
22d. PHYSICIAN'S NAME (Type) <i>Clarence J. Benson</i>		22e. ADDRESS <i>Pont Depot 1, Ind.</i>															
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>4/14/69</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Principis Cemetery</i>				23d. LOCATION (City or Town) (County) (State) <i>Principis Paul Md</i>									
24. FUNERAL DIRECTOR <i>W. B. Benson & Son</i>		ADDRESS <i>Principis</i>		25a. REC'D BY REGISTRAR DATE <i>APR 18 1969</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>											

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
<div> <div>05486</div> <div>05479</div> </div>									
<div> <div>1. DECEASED-NAME (Type or Print)</div> <div>First Middle Last</div> <div>Elmer Claus Johnson</div> </div>									
<div> <div>20. DATE KNOWN OF DEATH</div> <div>ESTIMATED</div> <div>Month Day Year</div> <div>4 8 1969</div> </div>									
<div> <div>2b. HOUR</div> <div>M</div> </div>									
<div> <div>3. SEX</div> <div>Male</div> </div>									
<div> <div>4. RACE</div> <div>White</div> </div>									
<div> <div>5. DATE OF BIRTH</div> <div>Aug. 22, 1893</div> </div>									
<div> <div>6. AGE (In years lost birthday)</div> <div>75 YRS</div> </div>									
<div> <div>7c. DATE PRONOUNCED DEAD</div> <div>Month Day Year</div> <div>April 8, 1969</div> </div>									
<div> <div>2d. HOUR</div> <div>M</div> </div>									
<div> <div>7a. BIRTHPLACE (State or foreign country)</div> <div>Sweden</div> </div>									
<div> <div>7b. CITIZEN OF WHAT COUNTRY?</div> <div>U.S.A.</div> </div>									
<div> <div>8. MARRIED</div> <div>NEVER MARRIED</div> <div>WIDOWED</div> <div>DIVORCED</div> </div>									
<div> <div>9. COUNTY OF DEATH</div> <div>Harford County,</div> </div>									
<div> <div>10. CITY OR TOWN OF DEATH</div> <div>Bel Air</div> </div>									
<div> <div>11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)</div> <div>1502 Honeysuckle Dr</div> </div>									
<div> <div>12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)</div> <div>Contractor</div> </div>									
<div> <div>12b. KIND OF BUSINESS OR INDUSTRY</div> <div>Construction</div> </div>									
<div> <div>13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE</div> <div>Maryland</div> </div>									
<div> <div>13b. COUNTY</div> <div>Harford</div> </div>									
<div> <div>13c. CITY OR TOWN</div> <div>Bel Air</div> </div>									
<div> <div>13d. INSIDE CITY LIMITS?</div> <div>YES</div> <div>NO</div> </div>									
<div> <div>13e. STREET AND NUMBER</div> <div>1502 Honeysuckle Drive</div> </div>									
<div> <div>14. FATHER'S NAME</div> <div>First Middle Last</div> <div>John Henry Benson</div> </div>									
<div> <div>15. MOTHER'S MAIDEN NAME</div> <div>First Middle Last</div> <div>Anna ?</div> </div>									
<div> <div>16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)</div> <div>No</div> </div>									
<div> <div>16b. SOCIAL SECURITY NO.</div> <div>(If yes give war or dates of service)</div> <div>217-20-3529</div> </div>									
<div> <div>17. INFORMANT</div> <div>HENRY JOHNSON (SON)</div> </div>									
<div> <div>ADDRESS</div> <div>9838 Harford Rd Baltimore, Md.</div> </div>									
<div> <div>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)</div> </div>									
<div> <div>PART 1. DEATH WAS CAUSED BY:</div> </div>									
<div> <div>IMMEDIATE CAUSE (a)</div> <div>ACUTE CORONARY OCCLUSION</div> </div>									
<div> <div>4109</div> <div>CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.</div> </div>									
<div> <div>(b)</div> <div>ARTERIO SCLEROTIC CARDIOVASCULAR DIS.</div> </div>									
<div> <div>DUE TO, OR AS A CONSEQUENCE OF</div> <div>WITH PRIOR PRECORONARY ATTACKS</div> </div>									
<div> <div>(c)</div> </div>									
<div> <div>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)</div> </div>									
<div> <div>19a. DATE OF OPERATION</div> </div>									
<div> <div>19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?</div> </div>									
<div> <div>20. AUTOPSY?</div> <div>YES</div> <div>NO</div> </div>									
<div> <div>21a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH</div> </div>									
<div> <div>21b. TIME OF INJURY Month, Day, Year</div> <div>HOUR A.M. P.M.</div> <div>19</div> </div>									
<div> <div>21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)</div> </div>									
<div> <div>21d. INJURY OCCURRED</div> <div>WHILE AT WORK</div> <div>NOT WHILE AT WORK</div> </div>									
<div> <div>21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)</div> </div>									
<div> <div>21f. LOCATION Street or R.F.D. No. City or Town County State</div> </div>									
<div> <div>22a. I certify that I took charge of the remains described above, held an Autopsy, Inspection, Inquiry, and in my opinion death resulted from: Natural causes, Accident, Suicide, Homicide, Undetermined manner</div> </div>									
<div> <div>CHIEF MEDICAL EXAMINER</div> <div>ASSISTANT MEDICAL EXAMINER</div> <div>DEPUTY MEDICAL EXAMINER</div> </div>									
<div> <div>22b. DATE SIGNED</div> <div>April 8, 1969</div> </div>									
<div> <div>ACTUAL SIGNATURE</div> <div>Philip W. Heuman, M.D.</div> </div>									
<div> <div>EXAMINER'S NAME (Type)</div> <div>Philip W. Heuman, M.D.</div> </div>									
<div> <div>ADDRESS (Street, city, town, or county)</div> <div>307 Hickory Ave., Bel Air, Md. 21014</div> </div>									
<div> <div>23a. BURIAL, CREMATION, REMOVAL (Specify)</div> <div>Burial</div> </div>									
<div> <div>23b. DATE</div> <div>4/11/69</div> </div>									
<div> <div>23c. NAME OF CEMETERY OR CREMATORY</div> <div>Moreland Memorial Hosp</div> </div>									
<div> <div>23d. LOCATION (City or Town) (County) (State)</div> <div>Baltimore, Maryland</div> </div>									
<div> <div>24. FUNERAL DIRECTOR</div> <div>ADDRESS</div> <div>Leonard J. Ruck Inc. 5305 Harford Road 21214</div> </div>									
<div> <div>25a. REC'D BY REGISTRAR</div> <div>DATE</div> <div>APR 9 1969</div> </div>									
<div> <div>25b. REGISTRAR'S SIGNATURE</div> <div>Charles J. Jager</div> </div>									

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|--|--|---|--------------------------|---|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| 05487 | | | | | 05480 | | | | |
| 1. DECEASED NAME (Type or print) | | | | | 2a. DATE OF DEATH | | | | |
| Howard Lee Johnson | | | | | Month 4 Day 17 Year 1969 | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | 7. IF UNDER 1 YEAR | |
| M | | W | | April 16, 1898 | | 71 YRS. | | MONTHS DAYS HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Md | | U.S.A. | | | | Harford | | US Govt. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Harford | | Harford Memorial | | Carpenter-Foreman | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Md | | Harford | | Joppa | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | 1409 Old Joppa Rd | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| George W. Johnson | | Georgia T. Linger | | no | | 216-24-322 4 | | Virginia G. Johnson, 1409 Old Joppa Road | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | 19. PART 1. DEATH WAS CAUSED BY: | | 20. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | 21. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| 492X | | IMMEDIATE CAUSE (a) Acute Cardiorespiratory Insufficiency | | | | 4 days | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | DUE TO, OR AS A CONSEQUENCE OF | | | | Several years | | | |
| | | (b) Chronic Cor - pulmonale | | | | Several years | | | |
| | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | |
| | | (c) Emphysema | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4-14, 1969, to 4-17, 1969, that (I) (we) last saw the deceased alive on 4-17, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | 22b. SIGNATURE | | 22c. DATE SIGNED | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | 22f. DEGREE | | 22g. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | |
| Edward C. Loo, M.D. | | Harford | | M.D. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | Apr. 19, 1969 | | Trinity Lutheran Cemetery | | Joppa Harford Md. | | | |
| 24. FUNERAL DIRECTOR | | 24a. ADDRESS | | 24b. REC'D BY REGISTRAR | | 24c. REGISTRAR'S SIGNATURE | | | |
| Howard K. McComas & Son, Abingdon, Md. | | | | APR 21 1969 | | Charles Judge | | | |

10527

THE HOUSE OF DEATH

THE HOUSE OF DEATH

April 11, 1905

CHICAGO, ILL.

Mr. J. H. ...

no

Howard E. ...
April 11, 1905
Chicago, Ill.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05481

| | | | | | | | | | | | | | | | | | | | |
|---|--|---------------------|---|--|--|---|--|--|--|--|--|--|-------------------------------|---|--|---|--|--|--|
| 1. DECEASED-NAME
(Type or print) <u>Adelia Mary Kelly</u> | | | 2a. DATE OF DEATH
Month <u>4</u> Day <u>27</u> Year <u>69</u> | | | 2b. HOUR
<u>1 P</u> M | | | | | | | | | | | | | |
| 3. SEX
<u>F</u> | | 4. RACE
<u>W</u> | | 5. DATE OF BIRTH
<u>April 23, 1892</u> | | | 6. AGE (In years
lost birthday)
<u>77</u> YRS. | | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN | | | IF UNDER 24 HRS.
HOURS MIN | | | | | | |
| 7a. BIRTHPLACE (State or foreign
country)
<u>Harford Co., Md</u> | | | 7b. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
<u>Harford</u> Md. | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
<u>Harford Grace</u> | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
<u>Harford Memorial</u> | | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired)
<u>Nurse (Registered)</u> | | | | 12b. KIND OF BUSINESS OR
INDUSTRY
<u>Medical</u> | | | | | | | |
| 13d. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE
<u>Md</u> | | | | 13b. COUNTY
<u>Harford</u> | | | | 13c. CITY OR TOWN
<u>Bel Air</u> | | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | 13e. STREET AND NUMBER
<u>623 Robert Ave</u> | | | |
| 14. FATHER'S NAME
First Middle Last
<u>John Leo Kelly</u> | | | 15. MOTHER'S MAIDEN NAME
First Middle Last
<u>Julia M. LARNER Kelly</u> | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service) | | | | 16b. SOCIAL SECURITY NO.
<u>212-01-3019</u> | | | | 17. INFORMANT (Sister 838-5287)
<u>Miss Helen C. Kelly</u> | | | | Address
<u>623 Robert Avenue
Bel Air, Maryland 21014</u> | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Pulmonary Embolism</u>
<u>887X</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
lost. (b) <u>Fractured (R) Hip</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) -
<u>Massive Pneumonia (L) lung with atelectasis</u> | | | | | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH | | | | | |
| 19a. DATE OF OPERATION
<u>4/25/69</u> | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
<u>Fracture (R) Hip</u> | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. <u>19</u> | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)
<u>FELL AT NURSING HOME 4/24/69</u> | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input checked="" type="checkbox"/>
at work at work | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State
<u>4-24, 1969, to 4-27, 1969</u> | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>4-24, 1969</u> , to <u>4-27, 1969</u> , that (I) (we) last
saw the deceased alive on <u>4/27</u> 19 <u>69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Charles J. Foley Jr. M.D.</u> | | | | | | | | | | | | | | | | 22c. DATE SIGNED
<u>4/27/69</u> | | | |
| 22d. PHYSICIAN'S
NAME (Type)
<u>CHARLES J. FOLEY JR M.D.</u> | | | | 22e. ADDRESS
<u>HARFORD GRACE, MD.</u> | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
<u>Burial</u> | | | | 23b. DATE
<u>April 29, 1969</u> | | | | 23c. NAME OF CEMETERY OR CREMATORY
<u>St. Ignatius Cath. Ch. Cem.</u> | | | | 23d. LOCATION (City or Town) (County) (State)
<u>Hickory, Harford Co., Maryland</u> | | | | | | | |
| 24. FUNERAL DIRECTOR
<u>Joseph William Foster</u> | | | | ADDRESS
<u>W. Parsonage & Williams Est.
Bel Air, Maryland 21014</u> | | | | 25a. REC'D BY REGISTRAR
<u>APR 29 1969</u> | | | | 25b. REGISTRAR'S SIGNATURE
<u>James J. Judge</u> | | | | | | | |

00887

Handwritten notes at the top of the page, including "1942" and "1943".

Handwritten notes in the middle section, including "John Lee Wells" and "1942-1943".

Handwritten notes in the lower middle section, including "1942" and "1943".

Handwritten notes at the bottom of the page, including "1942" and "1943".

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

| | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|---------------------|--|--|--|---|--|---|--|--|--|---|--|--|--|--|--|---------------------------|--|--|--|--|--|
| 05489 | | | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| 1 | | | | | | | | | | | | 05482 | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) <i>Josephine H. Klock</i> | | | | | | First Middle Last | | | | | | 2a. DATE OF DEATH
Month <i>4</i> Day <i>8</i> Year <i>69</i> | | | | | | 2b. HOUR
<i>7:45</i> M | | | | | |
| 3. SEX
<i>F</i> | | 4. RACE
<i>W</i> | | 5. DATE OF BIRTH
<i>Oct. 10, 1901</i> | | | | 6. AGE (In years last birthday)
<i>67</i> YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN | | | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country)
<i>Penna</i> | | | | 7b. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<i>Hartford</i> Md. | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
<i>Havre de Grace</i> | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<i>Hartford Memorial</i> | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
<i>House wife</i> | | | | 12b. KIND OF BUSINESS OR INDUSTRY
_____ | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
<i>Pa.</i> | | | | 13b. COUNTY
<i>Cambria</i> | | 13c. CITY OR TOWN
<i>Wilmore</i> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
<i>Box 83</i> | | | | | | | | | | | | | |
| 14. FATHER'S NAME
<i>James Brennan</i> | | | | | | 15. MOTHER'S MAIDEN NAME
<i>Ruth Martin</i> | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, <i>no</i> (or unknown) (If yes give war or dates of service) | | | | 16b. SOCIAL SECURITY NO.
<i>unknown</i> | | 17. INFORMANT
<i>Jesse T. Klock, Wilmore, Pa.</i> | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Intracerebral hemorrhage, massive</i>
4124
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <i>ASCVD</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>1 week</i>
<i>years</i> | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<i>Bronchopneumonia</i> | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
<i>yes</i> | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | | 21b. TIME OF INJURY
HOUR A.M. — Month Day Year
P.M. 19 <i>69</i> | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | 21f. LOCATION
Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>4-1, 1969</i> , to <i>4-8, 1969</i> , that (I) (we) last saw the deceased alive on <i>4/8, 1969</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
<i>Richard J. Calfer M.D.</i> | | | | | | DEGREE | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
<i>4/8/69</i> | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
<i>Richard J. Calfer M.D.</i> | | | | | | 22e. ADDRESS
<i>Havre de Grace, Md.</i> | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | 23b. DATE
<i>4-12-69</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>St. Bartholomew Cemetery</i> | | | | 23d. LOCATION (City or Town) (County) (State)
<i>Wilmore, Cambria, Pa.</i> | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR
<i>Lee A. Patterson & Son, Perryville, Md.</i> | | | | | | 25a. REC'D BY REGISTRAR
<i>APR 11 1969</i> | | | | 25b. REGISTRAR'S SIGNATURE
<i>Charles J. Jones</i> | | | | | | | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|--|--|--|--|--|--|---|--|--------------------------------|--|
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First | Middle | Lost | 2a. DATE OF DEATH | | | 2b. HOUR |
| FLORENCE W. LAIRD | | | | | | APRIL Month 7 Day 69 Year | | | 9:20 AM |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS | |
| FEMALE | | WHITE | | OCT. 8, 1884 | | 84 YRS. | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| STREET, MD. | | USA | | | | HARFORD Md. | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY |
| HAIR DE GRACE | | | HARFORD MEMORIAL HOSP | | | HOUSEWIFE | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| MD. | | | HARFORD | | FOREST HILL | | | 2418 FAIRVIEW DRIVE | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| ANDREW W. FAMOUS | | | MARY ANN ZARR | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, name and rank (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | | |
| No | | | 213-40-0385 | | IRMA L. FINDLEY, FOREST HILL, MD. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) 433.9 | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | |
| (b) Cerebral Artery Thrombosis | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (c) Generalized Arteriosclerosis | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| Diabetes Mellitus | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| | | HOUR A.M. Month Day Year P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION | | Street or R.F.D. No. | | City or Town | County |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4-3, 1969, to 4-7, 1969, that (I) (we) last saw the deceased alive on 4-7, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED | |
| DANTE U. MONAKIL, M.D. | | | | | | | | 4-7-69 | |
| 22d. PHYSICIAN'S NAME (Type) | | | | 22e. ADDRESS | | | | | |
| DANTE U. MONAKIL, M.D. | | | | 211 N. Union Ave. | | Harford Md. | | | |
| 23a. BURIAL, CREMATION, or other (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) | | (County) | (State) |
| BURIAL | | APR. 10, 1969 | | EMORY | | STREET HARFORD MD. | | | |
| 24. FUNERAL DIRECTOR | | | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| JOHN H. HARKINS, DELTA, PA. | | | | | | APR 10 1969 | | J. H. Judge | |

05630

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10-10-10

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

| | | | | | | | |
|---|--|--|--|---|--|--|--|
| Item 2 Film 412
4/30/69 kkl | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | Items 18 & 22a Film 412
4-30-69 ams | | | |
| 05491 | | MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | 05484 | |
| 1. DECEASED-NAME
(Type or Print) | | First Middle Last | | 2a. DATE KNOWN OF ESTI-DEATH MATED | | 2b. HOUR | |
| George Charles Lemmon | | | | Month Day Year | | M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years lost birthday) | |
| M | | W | | | | 58 YRS. | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | |
| Maryland | | U.S.A. | | | | Harford | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| White Hall | | Houch Road | | Laborer | | Farm | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| Md. | | Harford | | White Hall | | Norrisville Road | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16b. SOCIAL SECURITY NO. | |
| George Holmes Lemmon | | Laura Standiford | | Yes | | 213-20-6084 | |
| 17. INFORMANT | | ADDRESS | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>PERITONITIS</u> Acute Ethylism (0.44%) | | 21084 | |
| | | | | DUE TO, OR AS A CONSEQUENCE OF (b) <u>303.9</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| | | | | DUE TO, OR AS A CONSEQUENCE OF (c) | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Noturol causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined monner <input checked="" type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE | | 22b. DATE SIGNED | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | 22c. ADDRESS (Street, city, town, or county) | |
| Gerald C. Palmer | | 4-21-69 | | Bert A. M. | | | |
| EXAMINER'S NAME (Type) | | Gerald C. Palmer, M.D. | | 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | |
| | | | | Burial | | 4/24/1969 | |
| 24. FUNERAL DIRECTOR | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | 23e. REC'D BY REGISTRAR | |
| Charles E. Kurtz | | Bethel | | Madonna, Harford, Md. | | APR 23 1969 | |
| Jarrettsville, Md. | | 21084 | | 24. ADDRESS | | 24. REGISTRAR'S SIGNATURE | |

05491

11

Washington, D.C.

17-10-1941

Mr. J. Edgar Hoover

Department of Justice

Washington, D.C.

Dear Mr. Hoover:

I am writing to you regarding the matter of the

investigation of the activities of the

German agents in the United States.

I have been informed that you are conducting

a thorough investigation of this matter.

I am sure that your findings will be most

valuable to the Government.

I am, Sir, very respectfully,

Yours very truly,

Charles E. Smith

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05492

05485

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pen in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | |
|---|-------------------------|---|---|---|--------------------------------|--|--|
| 1. DECEASED-NAME
(Type or Print)
WINIFRED [REDACTED] V. MARBURG [REDACTED] | | First Middle Lost | | 2a. DATE KNOWN OF DEATH
ESTIMATED <input type="checkbox"/> unknown 19 | | 2b. HOUR
M | |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
11-15-1903 | 6. AGE (In years last birthday)
65 YRS. | IF UNDER 1 YEAR
MONTHS DAYS | IF UNDER 24 HRS.
HOURS MIN. | 2c. DATE PRONOUNCED DEAD
Month April Day 19 Year 1969 | 2d. HOUR
PM 11:00 |
| 7a. BIRTHPLACE (State or foreign country)
BALTIMORE, MD. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Harford | |
| 10. CITY OR TOWN OF DEATH
Fallston | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Bel Air Road | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
HESS SHOES | | 12b. KIND OF BUSINESS OR INDUSTRY
SALES | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MARYLAND | | 13b. COUNTY
HARFORD | | 13c. CITY OR TOWN
FALLSTON | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME
ABRAHAM | | First Middle Lost | | 15. MOTHER'S MAIDEN NAME
MARY | | First Middle Lost
BUSH | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)
NO | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT
MRS. BEATRICE M. HARRIS, APT. 1106, SILVER SPRING | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) ASCV Disease
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port 2, Item 1B.) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>
AT WORK AT WORK | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE
Gerald C. Palmer | | M.D.
Gerald C. Palmer, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | 22b. DATE SIGNED
April 20, 1969 | |
| EXAMINER'S NAME (Type) | | ADDRESS
SOL LEVINSON & BROS., 6010 REISTERSTOWN ROAD | | 25a. REC'D BY REGISTRAR
APR 25 1969 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE
4-22-69 | | 23c. NAME OF CEMETERY OR CREMATORY
ANSHE EMUNAH AITZ CHAIM | | 23d. LOCATION (City or Town) (County) (State)
BALTIMORE, MARYLAND | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 151A 4
45M - 1-69

| 05493 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 05486 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|---------------------------|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME (Type or print) Elizabeth Mary McKinney | | | | | | | | | | 2a. DATE OF DEATH April 23 1969 | | | | | | | | | | 2b. HOUR 11:30 P.M. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3. SEX Female | | | | | | | | | | 4. RACE White | | | | | | | | | | 5. DATE OF BIRTH July 13, 1882 | | | | | | | | | | 6. AGE (In years last birthday) 86 YRS. | | | | | | | | | | IF UNDER 1 YEAR MONTHS DAYS | | | | | | | | | | IF UNDER 24 HRS HOURS MIN | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) Scotland | | | | | | | | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | | 9. COUNTY OF DEATH Harford Md. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Havre de Grace | | | | | | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Harford Memorial | | | | | | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife | | | | | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY Home | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE Md | | | | | | | | | | 13b. COUNTY Harford | | | | | | | | | | 13c. CITY OR TOWN Aberdeen | | | | | | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | 13e. STREET AND NUMBER 13 New County Rd | | | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME First Middle Last Andrew Ramsey, (D) | | | | | | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last Elizabeth Henderson, (D) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown) No | | | | | | | | | | 16b. SOCIAL SECURITY NO. 215-48-2710 | | | | | | | | | | 17. INFORMANT Beatrice Bell, Rt. 1, Churchville, Md. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) 4379 | | | | | | | | | | DUE TO, OR AS A CONSEQUENCE OF Central Arteriosclerosis | | | | | | | | | | 1 yr. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | (b) Generalized Arteriosclerosis | | | | | | | | | | 5 yr. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | | | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | | | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4-5, 1969, to 4-23, 1969, that (I) (we) last saw the deceased alive on 4-23 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE [Signature] | | | | | | | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | | | | | 22c. DATE SIGNED 24 April 1969 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) Peter P. Rodman, M.D. | | | | | | | | | | 22e. ADDRESS 8 Low St., Aberdeen, Md. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | | | | | | | 23b. DATE 26 April 69 | | | | | | | | | | 23c. NAME OF CEMETERY OR CREMATORY Spesutia Cemetery | | | | | | | | | | 23d. LOCATION (City or Town) (County) (State) Perryman, (Harford Co.) Md. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR [Signature] | | | | | | | | | | ADDRESS Tarring Funeral Home, Aberdeen, Md. 21001 | | | | | | | | | | 25a. REC'D BY REGISTRAR DATE APR 28 1969 | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

05433

CONFIRMATION OF DEATH

THIS IS TO CERTIFY THAT the within and above named deceased person has been buried in the cemetery of the City of New York, at the place and on the date hereinafter mentioned.

APRIL 13, 1908

Witness my hand and seal of office this 13th day of April, 1908.

Notary

Commission Expires

Notary

Notary

Witness my hand and seal of office this 13th day of April, 1908.

Notary

Witness my hand and seal of office this 13th day of April, 1908.

Witness my hand and seal of office this 13th day of April, 1908.

Witness my hand and seal of office this 13th day of April, 1908.

Witness my hand and seal of office this 13th day of April, 1908.

Notary

Witness my hand and seal of office this 13th day of April, 1908.

Witness my hand and seal of office this 13th day of April, 1908.

APRIL 13, 1908

Notary

Witness my hand and seal of office this 13th day of April, 1908.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|--|---|---|-------------------------------|---|---|--|---|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) First Middle Last
MARIAN ANN McREYNOLDS | | | | | | 2a. DATE OF DEATH Month 8 Day 69 Year | | | 2b. HOUR
2030M | | |
| 3. SEX
FEMALE | | 4. RACE
CAUCASIAN | | 5. DATE OF BIRTH
17 JAN 1944 | | 6. AGE (In years last birthday)
25 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
ILLINOIS | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
HARFORD Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
EDGEWOOD | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
6210 BAKER CR | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
TEACHER | | | 12b. KIND OF BUSINESS OR INDUSTRY
School | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MARYLAND | | | 13b. COUNTY
HARFORD | | 13c. CITY OR TOWN
EDGEWOOD | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
6202 D BAKER CIRCLE | | |
| 14. FATHER'S NAME First Middle Last
ROY H. HOLDERNESS | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Martha -- Kollock | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) NO | | | 16b. SOCIAL SECURITY NO.
341-36-3001 | | 17. INFORMANT
HUSBAND | | Address
6202 D BAKER CIRCLE | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) POSSIBLE - PULMONARY EMBOLISM
450X DUE TO, OR AS A CONSEQUENCE OF
(b) DUE TO, OR AS A CONSEQUENCE OF
(c) DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
10-15 MIN | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
NO | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | | State | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8-APRIL, 1969, to _____, 19____, that (I) (we) last saw the deceased alive on 8 APRIL 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Harold Kirkpatrick M.D. | | | | | | DEGREE
ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
8 April 69 | | | |
| 22d. PHYSICIAN'S NAME (Type)
HAROLD KIRKPATRICK | | | | | | 22e. ADDRESS
6663 C REIDER CT EDGEWOOD, MD. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Removal | | 23b. DATE
Apr. 10, 1969 | | 23c. NAME OF CEMETERY OR CREMATORY
Dawson & Wiloff Funeral Home, Decatur | | 23d. LOCATION (City or Town) (County) (State)
Macon Ill. | | | | | |
| 24. FUNERAL DIRECTOR
Howard K. McComas & Son, Abingdon, Md. | | | | | | 25a. REC'D BY REGISTRAR
DATE APR 14 1969 | | 25b. REGISTRAR'S SIGNATURE
J. Charles Judge | | | |

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

05495

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05488

| | | | | | | | | | | | |
|--|---------|--|--|--|--|---|--|---|--|--|--|
| 1. DECEASED-NAME
(Type or Print) | | First | | Middle | | Last | | 2a. DATE KNOWN OF ESTI-
DEATH MATED <input checked="" type="checkbox"/> Month Day Year | | 2b. HOUR | |
| MELVIN | | | | | | MC WATTERS | | April 3 1969 | | M | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (in years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | 2c. DATE PRONOUNCED DEAD | |
| Male | White | 10-24-38 1930 | | 30 38 YRS. | | MONTHS DAYS | | HOURS MIN. | | Month Day Year | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | |
| S. Carolina | | U.S.A. | | | | HARFORD | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| FOREST HILL | | Pleasantville Road | | | | Farm Worker | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET AND NUMBER | | | |
| Md. | | Harford | | Forest Hill | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | Pleasantville Road | | | |
| 14. FATHER'S NAME | | First | | Middle | | Last | | 15. MOTHER'S MAIDEN NAME | | First Middle Last | |
| John W. McWatters | | | | | | | | Lula Widener | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | |
| No | | | | ? ? | | L.C. Wright | | Chester, S. Carolina | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Asphyxia
890X DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }
(b) Carbon monoxide
DUE TO, OR AS A CONSEQUENCE OF
(c) Conflagration | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? | | | |
| | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| | | 1:55 PM 4-3- 19 69 | | Found in burning house | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| | | House | | Pleasantville Rd. Forest Hill Harford Md. | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE | | Charles S. Springate | | | | M.D. | | 22b. DATE SIGNED | | April 3, 1969 | |
| EXAMINER'S NAME (Type) | | Charles S. Springate, M.D. | | | | | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | ADDRESS (Street, city, town, or county) | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | | |
| Burial | | 4-9-1969 | | Old Purity Cem. | | Chester S. Carolina | | | | | |
| 24. FUNERAL DIRECTOR | | ADDRESS | | 25a. RECEIVED BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| Wm. Cook-Brooks Towson, Inc. | | 1050 York Rd. Towson, Md. | | DATE | | 9 1969 | | P. Charles | | | |

5028

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15
45M - 11-59

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | | |
|--|--|--|--|--|---|--|---|--|--|--|--|------------------------------|--|--|
| 05496 | | | | | CERTIFICATE OF DEATH | | | | | 05489 | | | | |
| 1. DECEASED NAME
(Type or print) <i>David Ross Montgomery</i> | | | | | 2a. DATE OF DEATH
Month <i>4</i> Day <i>14</i> Year <i>69</i> | | | | | 2b. HOUR
<i>3:49</i> M | | | | |
| 3. SEX
<i>M</i> | | | 4. RACE
<i>W.</i> | | 5. DATE OF BIRTH
<i>Sept. 8/1899</i> | | | 6. AGE (In years last birthday)
<i>69</i> YRS. | | IF UNDER 1 YEAR
MONTHS | | IF UNDER 24 HRS
HOURS MIN | | |
| 7a. BIRTHPLACE (State or foreign country)
<i>Maryland</i> | | | 7b. CITIZEN OF WHAT COUNTRY
<i>U.S.A.</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
<i>Hartford</i> Md. | | | | | | |
| 10. CITY OR TOWN OF DEATH
<i>Laurel de Grace</i> | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<i>Harb. Mem. Hosp. Belnet</i> | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
<i>REMARK</i> | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived; if institution: Residence before admission) STATE
<i>Md.</i> | | | 13b. COUNTY
<i>Cecil</i> | | 13c. CITY OR TOWN
<i>Perryville</i> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
<i>Union Ave</i> | | | | | |
| 14. FATHER'S NAME First Middle Last
<i>John Thomas Montgomery</i> | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
<i>Anna — Devonshire</i> | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(If yes give war or dates of service)
<i>No</i> | | | 16b. SOCIAL SECURITY NO.
<i>Unknown</i> | | 17. INFORMANT
<i>Mary B. Montgomery</i> | | | Address
<i>Perryville Md.</i> | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Cerebro-vascular hemorrhages</i>
<i>4310</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <i>Hypertensive arteriosclerotic</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i>Vascular disease, cerebral condis</i> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>1 day</i> | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. <i>19</i> | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> of work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | |
| 22b. SIGNATURE
<i>Irvin L. Wachsmann</i> DEGREE
ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
22c. DATE SIGNED
<i>4/14/69</i> | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
<i>IRVIN L. WACHSMAN</i> | | | 22e. ADDRESS
<i>Laurel de Grace, Md.</i> | | | | | | | | | | | |
| 23a. BURIAL, CREMATION REMOVAL (Specify) | | | 23b. DATE
<i>April 17, 1969</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Harmony Chapel</i> | | | 23d. LOCATION (City or town) (County) (State)
<i>Laurel de Grace, Md.</i> | | | | | | |
| 24. FUNERAL DIRECTOR
<i>See J. Patterson</i> | | | ADDRESS
<i>Laurel de Grace, Md.</i> | | | 25a. REC'D BY REGISTRAR
<i>APR 17 1969</i> | | | 25b. REGISTRAR'S SIGNATURE
<i>Richard J. Judge</i> | | | | | |

30226

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | |
|--|--|---|---|---|---|
| 05497 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | 05490 | |
| Item 15 Film G411 4/24/69 kk | | | | | |
| 1. DECEASED NAME
(Type or print) | | First | Middle | Last | 2a. DATE OF DEATH
Month Day Year |
| RAYMOND | | F. | | MORGAN | APRIL 4, 1969 |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | 7. IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN |
| MALE | White | November 10, 1903 | | 65 YRS. | |
| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH | | |
| Md | US | HARFORD | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS or INDUSTRY | |
| HAURC de GRACE | HARFORD Memorial | Chief, Env. Test Sect. | | A.P.G. Md. | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER | |
| Md | HARFORD | Abingdon | | 800 Long BAR Rd | |
| 14. FATHER'S NAME | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | First Middle Last |
| Charles | B. | | Morgan (D) | Clara | Sarah/ Mahan, (D) |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | 16b. SOCIAL SECURITY NO. (If yes give war or dates of service) | 17. INFORMANT Address | | | |
| No | 216-05-8958 | Muriel Morgan, Abingdon, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 2307 Cardio - respiratory failure
DUE TO, OR AS A CONSEQUENCE OF
(b) Cachexia
DUE TO, OR AS A CONSEQUENCE OF
(c) Retroperitoneal neoplasia | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
6 hours
2 weeks
2 years |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Not complete |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to APRIL 4, 1969, that (I) (we) last saw the deceased alive on APRIL 4, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE | | 22c. DATE SIGNED | | | |
| James McC. Finney, M.D. | | April 4, 1969 | | | |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | | |
| James McC. Finney, M.D. | | Churchville, Maryland | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | |
| Burial | 7 April 1969 | Smith Chapel Cemetery, | | Churchville, (Harford) Md. | |
| 24. FUNERAL DIRECTOR | | ADDRESS | | 25a. REC'D BY REGISTRAR DATE | |
| Tarring Funeral Home, Aberdeen, Md. 21001 | | | | APR 8 1969 | |
| | | | | 25b. REGISTRAR'S SIGNATURE | |
| | | | | Charles Judge | |

65497

STATE OF TEXAS

IN SENATE, FEBRUARY 12, 1933.

REPORT OF THE
COMMISSIONER OF THE
LAND OFFICE
FOR THE YEAR
1932.

THE LAND OFFICE
OF THE STATE OF TEXAS
HAS THE HONOR TO
REPORT TO THE SENATE
THE RESULTS OF ITS
OPERATIONS DURING
THE YEAR 1932.

THE LAND OFFICE
OF THE STATE OF TEXAS
HAS THE HONOR TO
REPORT TO THE SENATE
THE RESULTS OF ITS
OPERATIONS DURING
THE YEAR 1932.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | |
|--|--|--|--|---|--|--|--|
| 05498 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 05491 | |
| 1. DECEASED-NAME
(Type or print) <i>Samuel R. Orr</i> | | First Middle Last | | 2a. DATE OF DEATH
Month <i>4</i> Day <i>6</i> Year <i>69</i> | | 2b. HOUR
<i>6 P M</i> | |
| 3. SEX
<i>Male</i> | | 4. RACE
<i>White</i> | | 5. DATE OF BIRTH
<i>SEPT. 25, 1911</i> | | 6. AGE (In years last birthday)
<i>57</i> YRS. | |
| 7a. BIRTHPLACE (State or foreign country)
<i>Maryland</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<i>Harford</i> Md. | |
| 10. CITY OR TOWN OF DEATH
<i>Harre-de-Grace</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<i>Harford Memorial Hospital</i> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
<i>AUTO MECHANIC</i> | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
<i>Md.</i> | | 13b. COUNTY
<i>Harford</i> | | 13c. CITY OR TOWN
<i>Darlington</i> | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 13e. STREET AND NUMBER
<i>DUBLIN ROAD</i> | | 14. FATHER'S NAME
First Middle Last
<i>Samuel Marshall Orr</i> | | 15. MOTHER'S MAIDEN NAME
First Middle Last
<i>Emmaline Reynolds</i> | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, (If yes give war or dates of service) <i>No</i> | |
| 16b. SOCIAL SECURITY NO.
<i>221-09-2970</i> | | 17. INFORMANT
Address
<i>Mrs. Thelma H. Orr, Dublin Road, Darlington Md.</i> | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Abdominal Carcinomatosis</i>
DUE TO, OR AS A CONSEQUENCE OF
(b) <i>Adenocarcinoma of Lt. Colon</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i></i> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>4 mos</i>
<i>12 mos</i> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION
Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>4-5-</i> , 19 <i>69</i> , to <i>4-6-</i> , 19 <i>69</i> , that (I) (we) last saw the deceased alive on <i>4-6-</i> , 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<i>W.H. Sadowsky</i> | | DEGREE | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
<i>4/6/69</i> | |
| 22d. PHYSICIAN'S NAME (Type)
<i>W.H. SADOWSKY MD</i> | | 22e. ADDRESS
<i>504 LEWIS ST. HARREDEGRACE</i> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 23b. DATE
<i>APR. 9, 1969</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Darlington Cemetery</i> | | 23d. LOCATION (City or Town) (County) (State)
<i>Darlington Harford, Md.</i> | |
| 24. FUNERAL DIRECTOR
<i>John V. Hopkins C.R.S.</i> | | ADDRESS
<i>Delta, Penna. 1734</i> | | 25a. REC'D BY REGISTRAR
<i>APR 10 1969</i> | | 25b. REGISTRAR'S SIGNATURE
<i>W. Charles Judge</i> | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1-69

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
|---|--|---|--|--|---|--|--|--|--|---|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED NAME
(Type or print) <i>Bonnie</i> | | First <i>M.</i> Middle <i>H.M.</i> Last <i>Pennington</i> | | 2a. DATE OF DEATH
Month <i>Apr.</i> Day <i>27</i> Year <i>1969</i> | | | 2b. HOUR <i>6:30</i> MIN <i>A</i> | | | | |
| 3. SEX
<i>Female</i> | | 4. RACE
<i>white</i> | | 5. DATE OF BIRTH
<i>March 1, 1929</i> | | 6. AGE (In years last birthday)
<i>40</i> YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN | | | |
| 7a. BIRTHPLACE (State or foreign country)
<i> Smythe Co. Virginia</i> | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<i>HARFORD Co.</i> | | | | | |
| 10. CITY OR TOWN OF DEATH
<i>HAVER de Grace</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<i>HARFORD Mem. Hosp.</i> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
<i>Assembly</i> | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>Shoe Mfg.</i> | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
<i>md.</i> | | 13b. COUNTY
<i>HARFORD</i> | | 13c. CITY OR TOWN
<i>Bel Air</i> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
<i>1811 Churchville Rd.</i> | | | |
| 14. FATHER'S NAME First <i>Avery</i> Middle Last <i>Dolinger</i> | | 15. MOTHER'S MAIDEN NAME First <i>Molly</i> Middle <i>M</i> Last <i>Baldwin</i> | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>no</i> (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO.
<i>229-34-0858</i> | | 17. INFORMANT <i>(Husband 838-6672)</i> Address <i>1811 Churchville Road Bel Air, Maryland 21014</i> | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Carcinomatosis</i>
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Ulcerating (L) Breast Carcinoma</i>
DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <i>174X</i> | | | | | | | | | | *APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>April 22, 1969</i> , to <i>April 27, 1969</i> , that (I) (we) lost saw the deceased alive on <i>Apr. 27</i> 19 <i>69</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<i>Charles J. Foley Jr.</i> | | DEGREE | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
<i>April 27, 1969</i> | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
<i>CHARLES J. FOLEY JR.</i> | | 22e. ADDRESS
<i>HAVER de GRACE, Md.</i> | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 23b. DATE
<i>April 29, 1969</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Mt. Zion Meth. Ch. Cem.</i> | | 23d. LOCATION (City or Town) (County) (State)
<i>Bel Air, Harford Co., Md. 21014</i> | | | | | |
| 24. FUNERAL DIRECTOR
<i>Joseph William Foster</i> | | ADDRESS
<i>W. Broadway & Williams St. Bel Air, Maryland 21014</i> | | 25a. REC'D BY REGISTRAR
<i>APR 29 1969</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove farban papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARTLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|--|--------|---|---|--|--|----------------------------|---|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First | Middle | Last | 2a. DATE OF DEATH
Month Day Year | | 2b. HOUR | |
| NELLIE | | | R. | | PERRY | April 4, 1969 | | 7:30 P M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | |
| Female | | Caucasian | | March 9, 1891 | | 78 YRS. | | MONTHS DAYS HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| West Virginia | | U.S.A. | | | | Harford Md. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Havre de Grace | | Citizens Nursing Home | | Housewife | | Home | | | |
| 13a. USUAL RESIDENCE (Where deceased admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Maryland | | Harford | | Aberdeen | | | | 402 S. Parke Street | |
| 14. FATHER'S NAME | | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | | First Middle Last |
| Remington | | | Bright | | (D) | Julia | | | A. Bright (D) |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | | |
| No | | 213-09-4931 | | Vernon T. Perry, Address
Aberdeen, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis, Recurrent</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Cerebral Arteriosclerosis</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u></u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1 month
3 yr |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11-13-1951 to 4-4-1969, that (I) (we) last saw the deceased alive on 4-4-1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | 22e. ADDRESS | | | | |
| Peter P. Rodman, M.D. | | | | | 8 Law Street, Aberdeen, Md. 21001 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Removal | | 9 April 69 | | Queens Point Cemetery | | Keyser, West Virginia | | | |
| 24. FUNERAL DIRECTOR | | | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Tarring Funeral Home, Aberdeen, Md. 21001 | | | | | | APR 9 1969 | | Charles Judge | |

DEPARTMENT OF THE INTERIOR

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Copy of the report of the
Commissioner of the General Land Office
to the President of the United States
for the year ending June 30, 1900



Printed by the Government Printing Office

1900

FOR STATE
HEALTH DEPT.

05501

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05494

| | | | | | | | | | | |
|---|---------|---|--------|---|---|---|---------------------------|---|-----------|--|
| 1. DECEASED-NAME
(Type or Print) | | First | Middle | Last | 2a. DATE KNOWN
OF ESTI-
DEATH MATED | | Month | Day | Year | 2b. HOUR |
| MICHAEL | | R. | | PETROGALLO | April 1 1969 | | | | | M |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (in years
last birthday) | IF UNDER 1 YEAR
MONTHS | | IF UNDER 24 HRS.
HOURS | | MIN | |
| Male | White | 2-13-1896 | | 73 YRS. | | | | | | |
| 7a. BIRTHPLACE (State or foreign
country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | 2d. HOUR | | |
| Pennsylvania | | U.S.A. | | | | Harford | | M | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR
INDUSTRY | | | | |
| Havre de Grace | | DORA Harford Memorial Hospital | | R.R. Worker | | Railroad | | | | |
| 13a. USUAL RESIDENCE (Where deceased
admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | |
| Maryland | | Harford | | Aberdeen | | | | 58 Norman Avenue | | |
| 14. FATHER'S NAME | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | First | Middle | Last | |
| Anthony | | | | Petrogallo (D) | Erminia | | | | Russo (D) | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | | |
| No | | 716-05-4804 | | Alfred Petrogallo, Aberdeen, Maryland | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u>
4109 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
last. (b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____ | | | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION
WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS
PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. P.M.
19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE
AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street,
factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , (Inspection <input checked="" type="checkbox"/> , (Inquiry <input type="checkbox"/> , and in my opinion
death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | | |
| ACTUAL
SIGNATURE <u>Gerald C. Palmer</u> M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | 22b. DATE SIGNED
4-2-69 | | |
| EXAMINER'S
NAME (Type)
Gerald C. Palmer, M.D? | | | | ADDRESS (Street, city, town, or county) Bel Air, Maryland | | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) | | (County) | (State) | |
| Burial | | 4 April 1969 | | Harford Memorial Gardens | | Aberdeen, (Harford) | | | | Md. |
| 24. FUNERAL DIRECTOR
<u>Kenneth B. Laing</u> | | | | ADDRESS
Tarring Funeral Home, Aberdeen, Md. 21001 | | | | 25a. REC'D BY REGISTRAR
DATE APR 7 1969 | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PD-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 11-1-69
45M - 1-69

| | | | | | | | | | | | | |
|---|--|--|--|--|--|---|--|--|-------------|-------------------|----------|--|
| 05502 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 05495 | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | First | | Middle | | Last | | 2a. DATE OF DEATH | | | 2b. HOUR | |
| William | | Henry | | Preston | | Month Day Year | | | Apr 28 1969 | | 3:00 M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | |
| male | | white | | November 25, 1896 | | 72 | | MONTHS DAYS | | HOURS MIN | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED | | NEVER MARRIED | | 9. COUNTY OF DEATH | | Md. | | |
| Maryland | | U.S.A. | | WIDOWED | | DIVORCED | | HARFORD | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | |
| Havre de Grace | | HARFORD Mem. Hosp. | | Chief, Railroad Div. | | U.S. Govt. | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET AND NUMBER | | | | |
| Md. | | HARFORD | | Havre de Grace | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | Apt 5D - Concord Cove Apts | | | | |
| 14. FATHER'S NAME | | First | | Middle | | Last | | 15. MOTHER'S MAIDEN NAME | | First Middle Last | | |
| William | | Thomas | | Preston | | (D) | | Josephine | | Hipkins (D) | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, No or unknown | | (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | | | | |
| No | | | | | | Matilda A. Preston, | | Havre de Grace, Md. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4123
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) due to coronary arteriosclerosis -
DUE TO, OR AS A CONSEQUENCE OF
(c) Atherosclerosis | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | 2hr | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/11, 1969, to 4/28, 1969, that (I) (we) last saw the deceased alive on Apr 28, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE | | 22c. DATE SIGNED | | 22d. ADDRESS | | | | | | | | |
| Dudley Phillips | | 4/28/69 | | Darlinton, Maryland | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | 22f. ADDRESS | | | | | | | | |
| Dudley Phillips, M.D. | | Darlinton, Maryland | | Darlinton, Maryland | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | | | |
| Burial | | 1 May 1969 | | Wesleyan Chapel Cemetery | | Havre de Grace, Maryland | | | | | | |
| 24. FUNERAL DIRECTOR'S NAME (Type) | | 24a. ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | | | |
| Tarring Funeral Home, Aberdeen, Md. 21001 | | | | MAY 5 1969 | | Charles Judge | | | | | | |

052503

UNITED STATES DEPARTMENT OF THE ARMY
OFFICE OF THE ADJUTANT GENERAL
WASHINGTON, D. C. 20315

TO: THE ADJUTANT GENERAL, ARMY
FROM: THE ADJUTANT GENERAL, ARMY

SUBJECT: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

9. [Illegible]

10. [Illegible]

11. [Illegible]

12. [Illegible]

13. [Illegible]

14. [Illegible]

15. [Illegible]

16. [Illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|--|--|--|--|--|----------------------------------|---|-------------------|--|--|
| 05503 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 05496 | | | | | | | | | |
| 1. DECEASED NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | | 2b. HOUR |
| Jarrett | | | Prigg | | | Month 4 Day 19 Year 69 | | | 5:20 P.M. |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| Male | | Negro | | March 10, 1882 | | 87 YRS. | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| Md. | | U. S. A. | | | | Harford Md. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Havre de Grace | | Green Spring Nursing Home | | Farmer | | Farm | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Md. | | Harford | | Aberdeen | | | | 733 Schopfield Road | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | |
| Abel | | | Prigg | | | Unknown | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | | |
| no | | | 220-50-4918 | | Mrs. Della Prigg - Aberdeen, Md. | | 733 Schopfield Rd | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) Cerebral Thrombosis | | | | | | | | | |
| 4122 DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (c) Hypertensive - Arteriosclerotic Cardiovascular disease | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/26, 1965, to 4/19, 1969, that (I) (we) last saw the deceased alive on 4/18, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | DEGREE | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED | |
| George T. Stansbury | | | | | | | | April 19, 1969 | |
| 22d. PHYSICIAN'S NAME (Type) | | | 22e. ADDRESS | | | | | | |
| George T. Stansbury | | | 569 Revolution St. Havre de Grace, Md. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | 4-25-69 | | Green Spring Cemetery | | Level, Harford, Md. | | | |
| 24. FUNERAL DIRECTOR | | | ADDRESS | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Otelia J. Bullock, Havre de Grace, Md. | | | 566 Federal St. | | | APR 23 1969 | | William J. Jones | |

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George T. Standish

x

10-11-11

10-11-11

10-11-11

10-11-11

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|---|--|--|--|---|--|---|--|--|----------------------------|--|--|
| 1. DECEASED-NAME
(Type or print)
Lida
Lyda | | Middle
Sylvester | | Lost
Rhodes | | 2a. DATE OF DEATH
Month Day Year
April 13 69 | | | 2b. HOUR
4.00 PM | | |
| 3. SEX
Male | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
July 28, 1893 | | 6. AGE (In years last birthday)
75 76 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN | | IF UNDER 24 HRS.
HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country)
Virginia | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Harford | | | Md. | | |
| 10. CITY OR TOWN OF DEATH
Havre de Grace | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Citizens Nursing Home | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Farmer | | 12b. KIND OF BUSINESS OR INDUSTRY
Agriculture | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | 13b. COUNTY
Harford | | 13c. CITY OR TOWN
Forest Hill | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
Walters Mill Road | | | |
| 14. FATHER'S NAME
First Middle Lost
Wilburn Rhodes | | 15. MOTHER'S MAIDEN NAME
First Middle Lost
Ruth Reedy | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown)
No | | 16b. SOCIAL SECURITY NO.
(If yes give war or dates of service)
216-09-9244 | | 17. INFORMANT (Son) 838-3091
Mr. ERNA J. Rhodes | | Address
16 Respect Mill Road
BEL Air, Maryland 21014 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) C.V.A.
4122 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) H.C.N.D.
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
Hour A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Lajos Mezei | | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
April 13, 1969 | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
Lajos Mezei, M.D. | | 22e. ADDRESS | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
April 16, 1969 | | 23c. NAME OF CEMETERY OR CREMATORY
BEL Air Memorial Gardens | | 23d. LOCATION (City or Town) (County) (State)
BEL Air, Harford Co, Maryland 21014 | | | | | |
| 24. FUNERAL DIRECTOR
Joseph William Foster | | ADDRESS
West Broadway & Williams Street
BEL Air, Maryland 21014 | | 25a. REC'D BY REGISTRAR
APR 15 1969 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | |

05504

CRIMINAL RECORD

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**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form CMS-Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|--|------------------|--|---|---|---|---|--|--|--|
| 05505 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 05498 | | | | | | | | | |
| 1. DECEASED-NAME
(Type or Print) <i>Viola Jenkins Ridenhour</i> | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <i>April</i> Day <i>12</i> Year <i>1969</i> | | | 2b. HOUR <i>2A</i> | | | |
| 3. SEX <i>F</i> | 4. RACE <i>W</i> | 5. DATE OF BIRTH <i>JAN. 20, 1905</i> | 6. AGE (In years last birthday) <i>64</i> YRS | IF UNDER 1 YEAR
MONTHS <i></i> DAYS <i></i> | IF UNDER 24 HRS.
HOURS <i></i> MIN <i></i> | 2c. DATE PRONOUNCED DEAD
Month <i>April</i> Day <i>29</i> Year <i>1969</i> | | 2d. HOUR <i>8A</i> | |
| 7a. BIRTHPLACE (State or foreign country) <i>N.C.</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH <i>Harford</i> | | | |
| 10. CITY OR TOWN OF DEATH <i>Harford</i> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Harford General Hospital</i> | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>HOUSE WIFE</i> | | 12b. KIND OF BUSINESS OR INDUSTRY <i>HOME</i> | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>N.C.</i> | | 13b. COUNTY <i>Yadkin</i> | | 13c. CITY OR TOWN <i>Cooleemee</i> | | 13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 13e. STREET AND NUMBER <i>5 Grove St</i> | |
| 14. FATHER'S NAME
First <i>Pleasant</i> Middle <i>Dalphos</i> Last <i>Jenkins</i> | | | 15. MOTHER'S MAIDEN NAME
First <i>Mattie</i> Middle <i>Plowman</i> Last <i></i> | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i></i> | | | |
| 16b. SOCIAL SECURITY NO. <i></i> | | | 17. INFORMANT <i>Russell W. Ridenhour</i> | | | ADDRESS <i>Cooleemee N.C. 27044</i> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Pulmonary Embolism</i>
DUE TO, OR AS A CONSEQUENCE OF
(b) <i>Immobilization</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i>Fracture R Femur</i> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>887X</i> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 19a. DATE OF OPERATION <i>4-20-69</i> | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <i>Fell at Friends House</i> | | | 20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. <i>4-20-69</i> P.M. <i></i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <i>Fell at Friends House</i> | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <i>APG Apartment Ho</i> | | 21f. LOCATION Street or R.F.D. No. <i></i> | | City or Town <i>Harford</i> | | County <i>Harford</i> State <i>MD</i> | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE <i>Gerald C. Palmer</i> | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> <i>Bel Air, W.</i> | | | 22b. DATE SIGNED <i>4-29-69</i> | | | |
| EXAMINER'S NAME (Type) <i>Gerald C. Palmer, M.D.</i> | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| ADDRESS (Street, city, town, or county) <i></i> | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i> | | 23b. DATE <i>MAY 1, 1969</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>FORK CHURCH CEM.</i> | | 23d. LOCATION (City or Town) <i>DAVIE</i> | | (County) <i>Co.</i> (State) <i>N.C.</i> | |
| 24. FUNERAL DIRECTOR <i>R. Madison Mitchell</i> | | | | ADDRESS <i>Harford Grace</i> | | 25a. REC'D BY REGISTRAR <i>MAY 1 1969</i> | | 25b. REGISTRAR'S SIGNATURE <i>James Judge</i> | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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|--|--|--|--|---|--|--|--|
| 05506 | | MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 05499 | |
| 1. DECEASED-NAME
(Type or print)
First Middle Last
MILDRED VIRGINIA SAMPSON | | | 2a. DATE OF DEATH
Month Day Year
April 12 1969 | | | 2b. HOUR
9:08 AM | |
| 3. SEX
Female | | 4. RACE
Caucasian | | 5. DATE OF BIRTH
December 27, 1913 | | 6. AGE (In years last birthday)
55 YRS. | |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Harford Md. | |
| 10. CITY OR TOWN OF DEATH
Havre de Grace, | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Brevin Nursing Home | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Housekeeper | | 12b. KIND OF BUSINESS OR INDUSTRY
Home | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | 13b. COUNTY
Harford | | 13c. CITY OR TOWN
Aberdeen | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 13e. STREET AND NUMBER
P.O. Box 395 | | 14. FATHER'S NAME
First Middle Last
Melvin T. Sampson | | 15. MOTHER'S MAIDEN NAME
First Middle Last
Nellie Virginia Cullum | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service) | |
| 16b. SOCIAL SECURITY NO.
None | | 17. INFORMANT
Allie Sampson, Box 395, Aberdeen, Md. 21001 | | 17. ADDRESS | | 17. ADDRESS | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Carcinomatous, abdominal</u>
1538 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Carcinoma of colon</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>2 1/4 years</u>
<u>2 1/2 years</u> | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 1/4 years
2 1/2 years | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (o) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11-6-1948, to 4-11-1969, that (I) (we) last saw the deceased alive on 4-11-1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Peter P. Rodman, M.D. | | 22c. DATE SIGNED
4-14-69 | | 22d. PHYSICIAN'S NAME (Type)
Peter P. Rodman, M.D. | | 22e. ADDRESS
8 Law Street, Aberdeen, Maryland 21001 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
14 April 69 | | 23c. NAME OF CEMETERY OR CREMATORY
Grove Presbyterian Cem. | | 23d. LOCATION (City or Town) (County) (State)
Aberdeen, (Harford Co.) Md. | |
| 24. FUNERAL DIRECTOR
Tarring Funeral Home, Aberdeen, Md. 21001 | | | | 25a. REC'D BY REGISTRAR
APR 16 1969 | | 25b. REGISTRAR'S SIGNATURE | |

1621

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|
| 05507 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 05500 | | | |
| 1. DECEASED-NAME
(Type or print) ^{First} Charles ^{Middle} Richard ^{Last} Sexton | | | | 2a. DATE OF DEATH
Month 4 Day 28 Year 69 | | 2b. HOUR
10:30 P.M. | | | |
| 3. SEX
M | | 4. RACE
W | | 5. DATE OF BIRTH
9/25/1930 | | 6. AGE (In years last birthday)
38 YRS. | | | |
| 7a. BIRTHPLACE (State or foreign country)
W. Va. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Harford Md. | | | |
| 10. CITY OR TOWN OF DEATH
Harford | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Harford Memorial | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
None | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md | | 13b. COUNTY
Harford | | 13c. CITY OR TOWN
Forest Hill | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 14. FATHER'S NAME
^{First} W. ^{Middle} F. ^{Last} Sexton | | 15. MOTHER'S MAIDEN NAME
^{First} Mollie ^{Middle} Catherine ^{Last} Sheets | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | 16b. SOCIAL SECURITY NO.
Unk | | 17. INFORMANT
Nellie G. Repton 1412 Bowles Terr Forest Hill, Md | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u>
1621 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Brain metastases</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Bronchogenic Carcinoma</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 19a. DATE OF OPERATION
3/24/69 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Pyloric stenosis | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 1969 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 3/17, 1969, to 4/28, 1969, that (I) (we) lost saw the deceased alive on 4/28, 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Charles J. Foley Jr. | | | | DEGREE
ATTENDING PHYS. | | MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | |
| 22d. PHYSICIAN'S NAME (Type)
CHARLES J. FOLEY JR. | | | | 22c. DATE SIGNED
4/28/69 | | | | | |
| 22e. ADDRESS
HAURE DE GRACE, MD. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE
5/3/69 | | 23c. NAME OF CEMETERY OR CREMATORY
Woodlawn | | 23d. LOCATION (City or Town) (County) (State)
Lewistown, W. Va. | | | |
| 24. FUNERAL DIRECTOR
Lewistown, W. Va. | | | | ADDRESS
25a. REC'D BY REGISTRAR
MAY 2 1969 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

02507

STATE OF TEXAS

COUNTY OF DALLAS

[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page]

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NOTARY PUBLIC
STATE OF TEXAS

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

| 05508 | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 05501 | | |
|--|--|--|-------|---|------|--|--|---|
| CERTIFICATE OF DEATH | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First | Middle | Last | 2a. DATE OF DEATH
Month Day Year | | 2b. HOUR |
| John | | | NMT | Smith | | April 18, 1969 | | 2216 M |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS |
| Male | | CAU | | 16 Nov 1881 | | 87 YRS. | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | |
| Austria, Hungary | | USA | | | | Harford | | Md. |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| m Aberdeen Pr. Gd. | | Kirk Army Hospital | | Fiber Mill Worker | | Fiber Mill | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER |
| Maryland | | Harford | | Aberdeen | | | | 638 Brenda Lane |
| 14. FATHER'S NAME | | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME First Middle Last | | |
| Unknown | | | | | | Unknown | | |
| 16a. VAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | | |
| No | | NA | | 221-09-5002 | | Maj(Ret) Luther C Hirschy Same Address | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardio-Respiratory Arrest
DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of Sigmoid with Metastases
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Unknown |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| Unk. | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | |
| 22a. I certify that (1) this hospital attended the deceased from XXXXXX and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) (Yes) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE | | 22c. DATE SIGNED | | 22d. PHYSICIAN'S NAME (Type) | | | | |
| Samuel Kaye | | April 18, 1969 | | Samuel Kaye, Cpt, MC M.D. | | | | |
| 22e. ADDRESS | | 22f. REGISTRAR'S SIGNATURE | | | | | | |
| US Kirk Army Hospital, APG, Md. | | Charles Judge | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | |
| Removal/Burial | | 19 April 69 | | All Saints Cemetery | | Eastburn Heights, Delaware | | |
| 24. FUNERAL DIRECTOR ADDRESS | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | |
| Tarring Funeral Home, Aberdeen, Md. 21001 | | | | APR 21 1969 | | Charles Judge | | |

$\frac{1}{2} \times \frac{1}{2} = \frac{1}{4}$

• 100 •

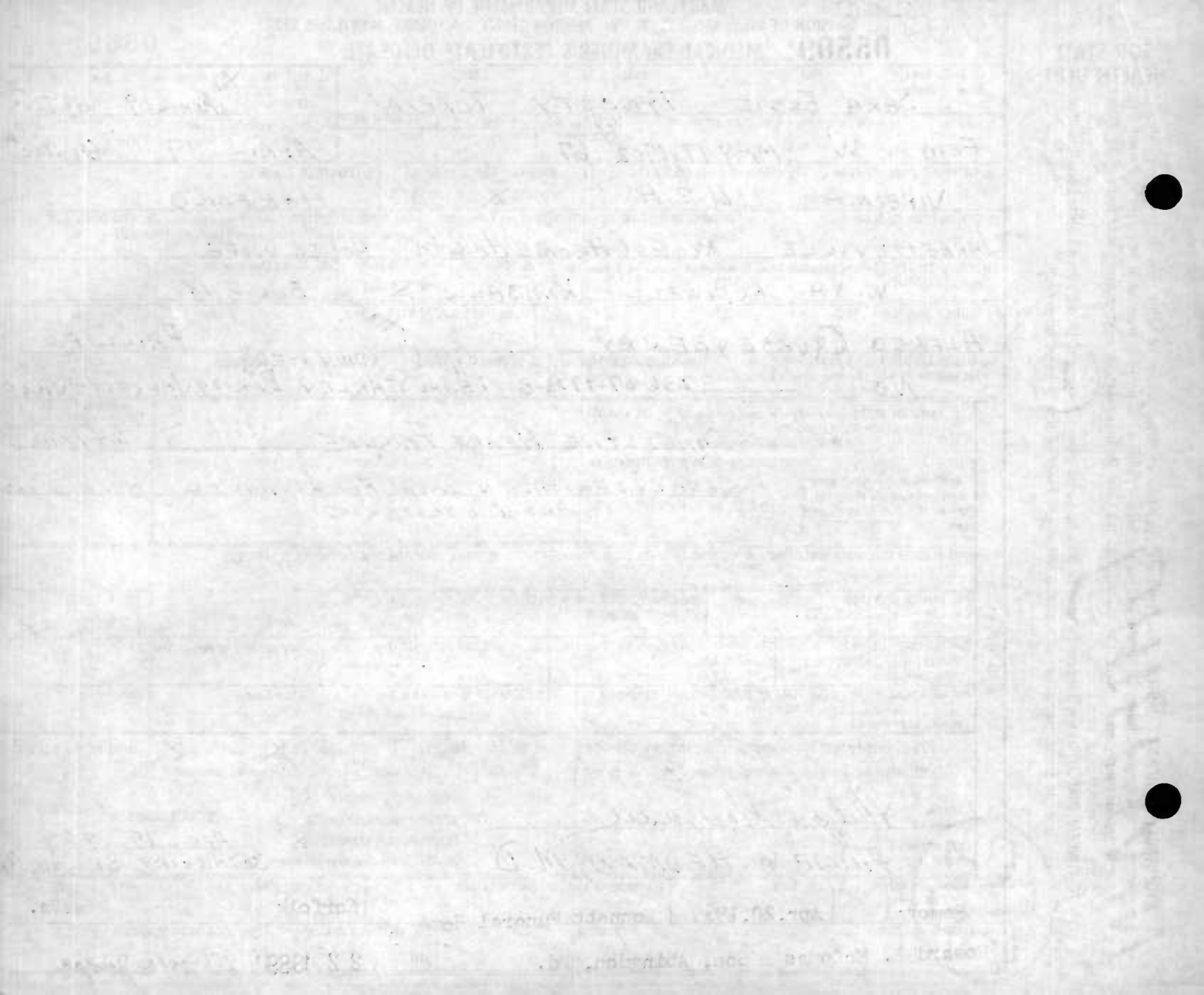
12. 2. 1951

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 05502 | | | |
|---|--|---------|--|--|------------------------------------|---|--|---|----------------------------|--|----------|-----------------------------------|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or Print) | | | First Middle Last | | | 2a. DATE KNOWN OF DEATH | | | Month Day Year | | 2b. HOUR | | |
| SARA ESSIE | | | TYNESTY | | | APRIL 19 | | | 1969 | | 9:00 M | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years at birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | 2c. DATE PRONOUNCED DEAD | |
| FEM | | W | | MAY 17, 1902 | | 67 YRS. | | MONTHS DAYS | | HOURS MIN. | | APRIL Day 19 Year 1969 11:00 M | |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED | | | NEVER MARRIED | | | 9. COUNTY OF DEATH | |
| VIRGINIA | | | U.S.A. | | | WIDOWED | | | DIVORCED | | | HARFORD Md. | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| JARRETT'S VILLE | | | | ROCKS CHROME HILL Rd | | | | HOUSE WIFE | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET AND NUMBER | | | |
| W. VA. | | | | MCDOWELL | | KIMBALL | | YES X NO | | Box 548 | | | |
| 14. FATHER'S NAME | | | First Middle Last | | | 15. MOTHER'S MAIDEN NAME | | | First Middle Last | | | | |
| ALFRED | | | QUESENBERY | | | ? | | | PHILLIPS | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | | 16b. SOCIAL SECURITY NO. | | | | 17. INFORMANT (DAUGHTER) | | | | ADDRESS | |
| NO | | | | 236-07-1722-B | | | | PEARL STANLEY | | | | Box 124 JARRETT'S VILLE | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE | | | | | | | | | | 24 HOURS | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | | |
| (b) SENILE DEBILITATION WITH FAR ADVANCED | | | | | | | | | | OVER 2 YRS | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | |
| ARTERIO SCLEROSIS | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? | | | | | |
| | | | | | | | | YES NO X | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH | | | 21b. TIME OF INJURY Month, Day, Year | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| | | | HOUR A.M. P.M. 19 | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. | | | City or Town County State | | | | |
| | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy, Inspection X, Inquiry X, and in my opinion death resulted from: Natural causes X Accident Suicide Homicide Undetermined manner | | | | | | | | | | | | | |
| ACTUAL SIGNATURE Philip W. Heuman | | | | | | CHIEF MEDICAL EXAMINER | | | | | | | |
| EXAMINER'S NAME (Type) PHILIP W. HEUMAN, M.D. | | | | | | ASSISTANT MEDICAL EXAMINER | | | | | | | |
| | | | | | | DEPUTY MEDICAL EXAMINER X | | | | | | | |
| | | | | | | ADDRESS (Street, city, town, or county) 307 HICKORY, BELAIR, MD | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | | | | |
| Removal | | | Apr. 20, 1969 | | Bennett Funeral Home | | | Norfolk W. Va. | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | 25a. REC'D BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | | |
| Howard K. McComas & Son, Abingdon, Md. | | | | | | DATE 22 1969 | | | Charles Judge | | | | |



FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 05503 | | | |
|---|--|--|--|---|---|---|--|--|---|--|---|---|--|
| 1. DECEASED-NAME (Type or Print) <i>Paul Woodrow Vanover</i> | | | | | | 2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/> 19 <input type="checkbox"/> <i>Unknown</i> | | | 2b. HOUR <i>M</i> | | | | |
| 3. SEX <i>M.</i> | | 4. RACE <i>W.</i> | | 5. DATE OF BIRTH <i>6/20/1914</i> | | 6. AGE (In years last birthday) <i>54</i> YRS | | IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> | | IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN. <input type="checkbox"/> | | | |
| 7a. BIRTHPLACE (State or foreign country) <i>N. Carolina</i> | | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH <i>Harford</i> | | | | |
| 10. CITY OR TOWN OF DEATH <i>Harford Md</i> | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Harford, Md 204</i> | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Retired</i> | | | 12b. KIND OF BUSINESS OR INDUSTRY <i>Gardener</i> | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE <i>Md.</i> | | | | 13b. COUNTY <i>Harford</i> | | | | 13c. CITY OR TOWN <i>Harford</i> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER <i>401 Well Lane</i> | |
| 14. FATHER'S NAME First <i>Harry</i> Middle <i>Vanover</i> Last <i>(du)</i> | | | | | | 15. MOTHER'S MAIDEN NAME First <i>Karna</i> Middle <i>Allistone</i> Last <i>(du)</i> | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>WW 2</i> | | | | | | 16b. SOCIAL SECURITY NO. <i>unk</i> | | 17. INFORMANT <i>Sadie B Vanover</i> ADDRESS <i>401 Well Lane Harford Md</i> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Bronchial Asthma</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>492X</i>
(b) <i>Emphysema</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | | | 21b. TIME OF INJURY Month, Day, Year <i>19</i> HOUR A.M. <input type="checkbox"/> P.M. <input type="checkbox"/> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <i>Gerald C Palmer</i> M.D. | | | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | | | | |
| EXAMINER'S NAME (Type) <i>Gerald C Palmer</i> | | | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | | | | |
| | | | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | | | |
| | | | | | | ADDRESS (Street, city, town, or county) | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE <i>4/30/69</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Balto. Md</i> | | | 23d. LOCATION (City or Town) (County) (State) <i>Balto Md.</i> | | | | | |
| 24. FUNERAL DIRECTOR <i>Don Harold Dean</i> ADDRESS <i>Harford Md</i> | | | | | | 25a. REC'D BY REGISTRAR <i>APR 30 1969</i> | | | 25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i> | | | | |

U.S. DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY

PLANT INDUSTRY



RECEIVED
JAN 10 1914

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|-------|--|--------|--|--|--|---|--|--|------------------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 05511 | | 05504 | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First | Middle | Last | 2a. DATE OF DEATH | | | 2b. HOUR | | |
| Thomas | | | J | | VEASEY | 4 Month 30 Day 69 | | | 0845 M | | |
| 3. SEX | | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. |
| m | | | CAU | | 7 MAY 1915 | | 53 YRS. | | MONTHS DAYS | | HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country) | | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | |
| Rhode Island | | | USA | | | | HAR FORD Md. | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Aberdeen Prov. Gd. Md. | | | US Kirk Army | | | SERVICEMAN | | | S/S | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | |
| MD. | | | HAR FORD | | ABERDEEN | | | | 527 LAW ST | | |
| 14. FATHER'S NAME | | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | | First | Middle | Last |
| Thomas | | | F | | VEASEY | Laura | | | M. | | Rioux |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | Address | | |
| YES 31 MAY 62 | | | | | | MARY V. VEASEY | | | Aberdeen Md. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. | | | | | | | | | | | |
| (b) <u>Bronchogenic Carcinoma</u> | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| (c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (H) (this hospital) attended the deceased from <u>19 Mar, 19 69</u> , to <u>30 Apr, 19 69</u> , that (H) (we) last saw the deceased alive on <u>30 Apr 19 69</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (H) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <u>C.M. DelValle, MD</u> DEGREE | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | | 22c. DATE SIGNED <u>30 Apr 69</u> | | |
| 22d. PHYSICIAN'S NAME (Type) <u>C.M. DelValle</u> | | | | | | 22e. ADDRESS <u>Kirk AH - APG - Md.</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Removal | | | 1 May 69 | | St Anne's Cemetery | | | Cranston, Rhode Island | | | |
| 24. FUNERAL DIRECTOR <u>Wesley McCowley Sr.</u> Tarring Address <u>Aberdeen, Md. 21001</u> | | | | | | 25a. REC'D BY REGISTRAR <u>MAY 5 1969</u> | | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | |

85211

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OFFICE OF THE
DIRECTOR OF THE
BUREAU OF THE
CENSUS



1950



U.S. GOVERNMENT PRINTING OFFICE